Neighborhood Planning for Community Revitalization

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Logan Park and St. Anthony East Community Health Program: Needs and Expectations for a Healthy Community

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Conducted on behalf of Logan Park-St. Anthony East
Community Health Program
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By Blythe Burkhardt
June 1999

Prepared for:
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Introduction

The NE Minneapolis neighborhoods of Logan Park and St. Anthony East (see Appendix 1 for map of neighborhoods) have joined together and directed NRP funds towards creating a community health program. The idea for this program stems from the Living At Home/ Block Nurse Program, Inc. model of community health care currently being implemented in several St. Paul neighborhoods and a few Minneapolis neighborhoods. Where the Logan Park- St. Anthony East program differs, is in its target clientele. The Living At Home/Block Nurse Program is strictly for elderly residents, however, the steering committee for the Logan Park & St. Anthony East Community Health Program hope to assist the elderly as well as young and low income families.

It is hoped that this will be a more holistic program encompassing the entire neighborhood not simply one age group of residents. Goals of the program are to provide the following:

- In home health care services for neighborhood residents to enable them to stay in their homes.
- Outreach to at-risk populations who have difficulty accessing health care to assist them in obtaining health care and be aware of health care resources.
- Assistance to single parent or low-income families to help meet their health care needs and to access available resources for prenatal health care and nutrition.
- Transportation assistance to enable residents to access health care resources.

To meet these goals the Community Health Program (CHP) will contract with a home health agency to provide skilled care from visiting nurses and home-health aides, provide community support and services through a pool of volunteers, and also coordinate with existing services being provided in the neighborhoods.

It is hoped that the Community Health Program will be in effect sometime in late summer 1999. To guide them in their development of the program, the neighborhood steering committee commissioned a research project to assess the needs of the community in regards to the community health program. This is the report of that research project. There are three stages to the research project. Stage one consists of researching other Block Nurse or community health related programs in the Twin Cities and state of Minnesota and gathering statistical information relating to health issues as part of a needs assessment study for the NE neighborhoods. The second stage focuses on visiting with local schools, health care providers, and social services agencies to assess their expectations of a community health program and find possible avenues of collaboration. The third stage involves going out into the public to speak with residents of these neighborhoods to determine their needs and expectations for a community health program.

Stage I - The Model

As the initial idea for the Community Health Program stems from the Living At Home/Block Nurse Programs (LAH/BNP) at work in several St. Paul and southeast Minneapolis neighborhoods, one of my first steps as a researcher was to take a look at the LAH/BNP model. To get an idea of how the model works I consulted Bill Lorimer, Project Director, and Malcolm Mitchell, President, of LAH/BNP, Inc.

According to the two of them the Living At Home/Block Nurse Program is a self organized, community organization whose mission is to serve the elderly, to keep them living in their homes comfortably. It is a grassroots effort with a strong base in the community. The effort of the community is important because the manner in which it evolves is key to the program's success and survival. Each LAH/BNP works with other organizations within the community in an effort not to duplicate services but to coordinate existing services. The idea is to provide what Lorimer called a "seamless spectrum of care". As its mission statement implies the focus of the LAH/BNP is on the elderly, the population 65 or older in the neighborhood who could use assistance. The assistance can include "minor" support like grocery shopping, or friendly visits, or walk in the neighborhood. The goal is to keep seniors connected with the community. Something "minor" can make an important difference in a person's life. The LAH/BNP is characterized by two parts – skilled nursing services provided through a contract with a home health agency and non-skilled volunteer services. Both Lorimer and Mitchell feel that a program should start the social supports, the volunteer services, early before the senior start to get frail and need the nursing aspect of it.

The creation of a LAH/BNP can take anywhere from 18 months to 2 years and even sometimes longer. Mitchell and Lorimer break it down into four phases. Phase one usually takes at least six months. This is what they called the "sweat equity" phase. In this initial stage the community members gather together to collect demographic information, do some preliminary needs assessment, make linkages with local organizations, start building financial support and begin writing the by-laws of the program.

Phase two, which can take six months to a year, is the more formal organization of the program. There is a steering committee in place which is moving toward the evolution of a strong board. A name for the program is decided on. The committee begins to look at links with nursing services. Volunteers are organized and volunteer services are being provided. Outreach and publicity of the program is underway and must be accompanied by trust-building within the community. The program should have a very natural feel to it, so volunteers have the sense that they're not working, just visiting their friends. There is an attempt to identify people who are frail and in need of nursing services. Efforts at fundraising are also ongoing at this time.

In phase three the program has established a contract with a nursing service provider and is beginning to provide nursing services. By now the board is strong and solid and "has their feet on the ground". Fundraising is still ongoing and volunteer services are still being provided. Phase four is simply the continuation of the program. It includes the expansion of the program through the number of people reached and the number of services provided. Also, new aspect of the program such as multi-generational activities are added here.

Lorimer and Mitchell recommend strongly that the LAH/BNP program should not be organized in a top-down approach. It shouldn't come out of a decree where someone says, "this think is going to happen in six months, how do we do it?", but instead the

question should be "how do we generate neighborhood ownership?". There are several health agencies who give referrals, but the goal of the LAH/BNP is to take responsibility for the whole person as a "focused entity". They don't want the operation of the program to fall into a typical referral pattern where the client calls and then gets referred somewhere else. Mitchell and Lorimer maintain that all that does is shift responsibility for the person from the LAH/BNP to wherever they are referred. A lot of places think they can just get a call, make a referral and then just wash their hands of the client because they have been referred to someone else. They say that while referrals are necessary in some situations, they must be referral with follow-up - still keeping responsibility for and an interest in the client.

LAH/BNP, Inc. recommends setting boundaries and defining who will get service. Although, defining what service people will get is not always easy because the definition has to be broad enough to cover whatever they need to help their health. Mitchell stated that the organization is not very fond of needs assessment in terms of official census data, surveys and other impersonal ways of data collection. They consider helpful needs assessment to come from a bottom-up approach where the individual and his or her needs are the main focus.

Lorimer and Mitchell strongly recommend that multiple avenues of funding be sought out. In the urban neighborhoods they have estimated that it costs $50,000 to $60,000 to operate a BNP. The budget does not include the money that is spent on health care by third party payers like Medicare. They suggest annual fundraising campaigns within the community. These campaigns have two outcomes: 1) to build awareness for the program in the community, and 2) to encourage neighbors to help neighbors. Bill Lorimer stated that they usually start out slow, but in five years you can see "nice money" as trust is built within the community and people start seeing or feeling the results of the what the program is doing. It is important to have not just public support but strong neighborhood and community support as well. This means both public and private funds. In the typical LAH/BNP fundraising is the responsibility of the board, however, in some cases the larger organization LAH/BNP, Inc. help to identify and secure further funding opportunities.

According to Lorimer and Mitchell, the key to creating a strong program and one which is flexible is to have a strong board. "The strength is the people". They caution that the program should not become a marketing arm of the clinics or hospital. The goals of the program should always focus on the local group. It should not be an organization saying "this is what we will do to help you"; instead, it should be the client saying "this is what I need you to do to help me".

When it comes to coordinating existing services, the two men suggested two ways in which it can be done. On is to have the board or steering committee and program staff talk with the existing agencies to find out what services they provide and where collaboration could come about. There should be some kind of community liaison with other organizations to get and give referrals, share resources, etc. The second is through fundraising which is also a building of relationships. It involves outreach and finding ways of the building trust in the community, finding people to help and be helped. Sometimes local businesses or organizations will know of people who need these services. There can be help in the form of giving referrals as a consultant or direct contact, but again they warn that everything should not be totally referred out. Mitchell calls this the "systems answer", to refer everything out, to use all nursing agencies instead of just one. The LAH/BNP model is based on forming a partnership with the nursing agency so that the two become a team and so the nursing agency takes some stake in the

neighborhood. This is why the programs often try to hire nurses and home health aids from the community. Lorimer and Mitchell say that you can't just refer and be done, because you are never done. The patient is never discharged in this type of program. The goal is also not to replace services but enhance them, and always the question to ask should be "what can we do to help you?"

In order to use the name Living At Home/Block Nurse Program the program must adhere to the tenets of LAH/BNP, Inc.: focus on the elderly, local government through neighborhood members on the board, a broad definition of care (whatever a person needs to feel good, get better, stay in their homes), contract with a home health care agency, a combination of volunteering and nursing, non-duplication but coordination of existing services, and 501C3 non-profit status.

While this gives a general outline of the LAH/BNP model, the Logan Park-St. Anthony East Community Health Program steering committee requested information on the functions of specific LAH/BNPs. Because members of steering committee are familiar with some of the staff of the SE Seniors LAH/BNP, I was directed to find out more about their daily operations and so spoke with four people affiliated with their program: the director, volunteer coordinator, home health nurse and a board member. However, like the director of the St. Anthony Block Nurse Program said, "each [program] has its own unique way of doing things because we're all in unique locations", For this reason I sought to learn about the operations of some other LAH/BNPs in the area and so spoke with staff members from four other programs in addition to SE Seniors (Merriam LAH/BNP, Nokomis SE Seniors, Longfellow/Seward SE Seniors, and Summit Hill LAH/BNP). In talking with representatives from these programs several themes emerged: origins of the program, staffing, home health care, services provided, volunteering, publicity, record keeping, evaluation, advice/suggestions for the LP-SAE CHP.

Origins

It is true that each LAH/BNP is unique even in their origins. According to board member Laura Weinberg SE Seniors started when one woman in the Prospect Park area came home from the hospital and was assigned a home health aide by the hospital. She hated the home health aide and was miserable so called a nurse in the neighborhood who had been conducting blood pressure checks. That nurse came in, essentially drove out the home health aide and got the woman's health plan straightened out. This was the major impetus for the program. A steering committee was formed and they know the Block Nurse program had been going successfully in St. Anthony park so took them as a model.

Membership on the steering committee was entirely voluntary and the committee later became a board. The first thing they did was start fundraising. They were first an outgrowth of Pratt Community Education and broke off on their own once they were financially and organizationally stable.

Both Weinberg and SE Seniors director, Mary Quirk, said that the program was really begun by nurses who live in the neighborhood. Neither one talked very much about assessing the needs of the community before starting the program. Weinberg said "I think we just based the program on whatever was already being done for seniors in other [LAH/BNP] programs".

The Nokomis and Longfellow/Seward programs started off differently. These two were originally Medicare funded projects undertaken to prove that it costs less to keep seniors in their home, and have now become full-fledged LAH/BNPs. In the project

stage, the programs both focused more on providing nursing services rather than volunteer services to all ages of senior no matter what their health situation was. Now the nurses "play a more complete role" and more non-skilled volunteer services are being provided. A sliding fee scale has been established and clients have been limited to those 65 and older, although Longfellow/Seward indicated they would like to expand services to other age groups when they felt more financial stability.

Staff

In terms of staffing, each program has own combination of staff members to provide services. The Nokomis program currently has eight staff people since it is still moving from a Medicare project to a LAH/BNP. They have one project director whose main duties are fundraising and grant writing and works 20 hrs/week. Two social services coordinators work 20 hrs/wk as well. Nokomis also has four nurses and one home health aide on staff, though they are expecting to reduce their staff by two nurses.

The Longfellow/Seward program also four nurses, two of whom do general health promotion for the community (one helps with grief and loss and one does general medical counseling) and two who do the actual hands-on nursing services. They also have a program director, a service coordinator and an office assistant, all of whom work 20 hrs/week.

The Summit Hill LAH/BNP has three staff members. The have a program director who works 20 hrs/week. The duties of this position are to report on the use of grant money, like with other organizations, write article, deal with the board, and supervise nurse and other employees. The service director, who works 30 hrs/week does non-nursing services, establishes links with local resources, makes home visits and recruits and trains volunteers. The third staff member is a nurse who works 15-20 hours per week and is a resident of the neighborhood employed by Wilder Foundation.

Merriam LAH/BNP has only one staff member in addition to their visiting nurse. This is a full time position in which the staff member does administration, volunteer coordination including recruiting, training and placing of volunteers.

The SE Seniors program has two staff members, a program director and volunteer coordinator, in addition to a nurse and two home health aides. (For a description of the duties and responsibilities of those positions see Appendix ?). The SE Seniors visiting nurse Darla Wexler considers her duties to be the following:

- Make initial (free) visit to the patient to do assessment, consults doctors and sets up an health plan
- Decides how many nurse visits and home health aide visits are necessary and how often they should occur
- Does a safety check on the house, can recommend chores, repairs, etc. to be dome by volunteers
- Calls in and orders prescription medicine, checks amount of medications to determine whether more need to be ordered.
- Sets up medicine schedule – puts pills into little day reminder boxes when necessary
- Keeps an out for other volunteer needs
- Checks on how things are going with the home health aide.
- If things get really bad, can recommend that the patient no longer stays in this or her home.

Home health aides can do foot care (if trained) and bathing. They are not allowed to transport patients but can pick up groceries, fix meals and do some general housework. They also check on nutrition. One of SE Seniors home health aides also cuts hair.

Home Health Care

There are a variety of home health care agencies with which the various LAH/BNPs form contracts. Nokomis and Longfellow/Seward have both contracts with Healthspan Hospice Homecare and in the Nokomis program the nurses are residents of the neighborhood. Summit Hill LAH/BNP has contract with Wilder Home Health, a branch of the Wilder foundation. Their nurse is a resident of the neighborhood as well. The Merriam program had "a very good relationship with MVNA (Metropolitan Visiting Nurses Association)" but switched to Wilder Home Health because of their focus on St. Paul. Their director highly recommends MVNA as a home health agency.

SE Seniors has a contract with MVNA. Their nurse, Darla, is a part time employee of MVNA and contracts strictly with SE Seniors. SE Seniors' home health aides also come form the neighborhood and are sent to MVNA for hire. Some have to go through training which is provided by the nursing agency. Laura Weinberg noted that this a key component of the LAH/BNP, Inc. program, that help come from within the neighborhood. It serves to provide what Malcolm Mitchell called "continuity of care" and can also provide part time employment for those in the neighborhood who need or want it. One thing to be aware of when contracting with a nursing agency, Darla said, is that MVNA and possibly some other home health agencies have divided up their nurses according to specialty areas (i.e. pediatrics, geriatrics, etc.) Although they are supposedly trained to deal with all ages in the general population, this division nurses by experience with particular age groups may make a difference in starting a program intended to cater to a whole realm of age groups.

Services

The uniqueness of each LAH/BNP really shows through in the services that they provide. In addition to providing home nursing services, the Nokomis program takes transportation requests, helps with grocery shopping, provides respite care and friendly visiting, and performs home safety checks in the summer. They have also set up a telephone tree for publicizing health promotion events in the neighborhood and also send letters and make phone calls when a neighbor dies or when a volunteer has an anniversary of becoming involved with the program.

The Longfellow/Seward program has a senior social once a month with a different speaker each time. The also coordinate two exercise programs at two different locations. The exercises are appropriate for seniors and those who are chair bound, they are ones that can be practiced at home. They have blood pressure clinics in their office once a week. To provide referrals for resources they have established a mini linkage line ("a mini 411") of services available. Longfellow/Seward volunteers provide services like friendly visiting, minor chores, transportation and house-sitting during funerals. The director the program indicated that these services are intended to be "stop-gap" and clients are referred to more intense programs if needed.

In the Merriam LAH/BNP a nurse provides blood pressure checks, medication schedule set-up, and wound care. If needed, physical therapy can also be provided through the home health care agency. Home health aides do laundry, house cleaning,

bathing, and meal preparation. Merriam volunteers make friendly visits to clients, help with laundry, provide transportation to and from medical appointments and perform light household chores. They also work with the local neighborhood association to do yard clean-ups.

The Summit Hill LAH/BNP provides home health care through a nurse and home health aide. They give referrals for housekeeping, respite care, and chores to other agencies, but also have a small corps of volunteers who will also provide these services. They provide friendly visiting, help with grocery shopping, blood pressure checks and home safety tours. They also organize three socials per year for seniors in the neighborhood.

For SE Seniors clients are identified when they call and request services themselves or a family member, medical facility or nursing service make the request. The program cal call the nurse who is contracted to work for them directly, they don't have to call MVNA. The nurse then goes to the patient and does an initial assessment, set up a care plan and assess the situation for needs such as chores and delivered meals. They can then request volunteer help from the program. According to Mary Quirk, people seldom call and request specifically for a volunteer, however the bulk of the services they provide are transportation and chores. A sliding fee scale for patient who are not covered by insurance or are underinsured is set up by the board. Billing and payments are administered by MVNA. While there is no cap on subsidies set, Laura Weinberg suggests that this might be a good thing to include in the program's by-laws.

Michelle Lichtig, SE Seniors' volunteer coordinator, noted that their typical client is a woman in her 80s living alone. She usually has encountered some type of physical loss which is creating the need for some volunteer assistance and/or nursing aid, and it is usually their eyesight that is the problem. Many clients are living alone, but Michelle also said that married couple can have equal need. SE Seniors' volunteers focus strictly on visiting and providing companionship, but that can take many forms, from going grocery shopping to taking walks in the neighborhood together. The program has one new volunteer who does chores and small home repairs, but this considered a separate service. SE Seniors is also looking into expanding services for housecleaning, laundry, etc. by contracting with a homemaking agency.

Other services include blood pressure checks in high rise buildings and about four to ten health promotion classes per year. Michelle also has established multigenerational programs between SE Seniors and Marsh school. She does special programs where the school kids can "try on old age" to sensitize them to what it is like to be elderly. The students then go to a senior high rise and bake cookies and play card with the residents and also plant flowers for the senior residents of the neighborhood. She said the board feels that these multigenerational programs are one of the strongest parts of the SE Seniors program.

Volunteer Training and Placing

For SE Seniors, Michelle has a two session training program to orient volunteers to the program. It's important for the volunteer coordinator to know the clients in order to match up clients and volunteers. Michelle usually gets to know the volunteers through training. The training session begins by having each volunteer fill out a coat of arms describing themselves. Sometime she asks them to give the history of their names. These are ice breaker activities so that she can get to know the volunteers. She said it kind of takes a "sixth sense" to get to know people and be able to match them up. She

also visits the clients to get the know them, but also knows about them through other people like the visiting nurses. Some clients have been volunteers themselves and then come to want or need a volunteer of their own. The second part of the volunteer orientation includes having a lecture from Helen Kivnick (author *of Vital Involvement in Old Age*) about communicating and forming relationships with the elderly.

Michelle has found that the timing of the volunteer orientation sessions makes a large difference. She used to do three or four training sessions per year, and then when a volunteer called and offered his or her services she would have to ask them to wait until the next training session. She lost some potential volunteers because of this and recommends doing individual training and not waiting for one class. She now does one-on-one or small group training and has them start their volunteer visits. Once or twice a year she invites them to hear Helen Kivnick speak as a group later.

Michelle says so far there have been no disasters but once she had a woman who did not enjoy it but was dedicated and kept spending time with the client. Michelle cautions that a program doesn't really want that to happen because the idea is for everyone to be compatible. The most difficult time for both the volunteers and the clients is the period between the first and second visits. On the first visit Michelle will be there for the first fifteen or twenty minutes to introduce the two and make sure things will be alright. Then she leaves and encourages the two to stay and get to know each other for another 45 minutes or so. The volunteer is encouraged to make the next contact through a phone call and Michelle will follow up to make sure that is done. She recommends that it isn't longer that a month between the first visit and the second visit. Michelle says the hard part is the decision of the client to accept the phone call right away. Then, the nature of the relationship should be decided by the volunteer and the client depending on what each one wants to do.

SE Seniors has had a mix of people serve as volunteers: nurses, grad students, professors, teachers. Michelle said the majority of volunteers are nurses and teachers, not "young mom types". She said that many people find a personal incentive in volunteering, they just like older people or maybe they miss their grandparents. She reminded me that "the volunteer advertisements say 'companionship and conversation' and that goes both ways."

Michelle warns that is this program there are certain risks involved because what you are doing is asking people to make friends, form a relationship with someone who is nearing the end of their life. Some thing the program has not really dealt with much is helping volunteers through the grieving process. Also, when clients move out of the neighborhood or cannot stay in their homes any longer and must move to a nursing home, the volunteer can deiced to keep the visiting going and/or form a new relationship with someone else in the neighborhood.

Other LAH/BNP vary in the length and amount of training they give their volunteers. Nokomis has a 45 minute training session, Merriam has one-on-one training for about an hour, Summit Hill has a one to one and a half hour orientation, and Longfellow/Seward has a two and a half hour group session and then a one hour individual training session. A training manual is provided. Similar topics are covered in each of these programs' training sessions, first of which is the program's goals and philosophy. In the orientation sessions volunteers learn tips of breaking the ice, and ideas on how to communicate with seniors. They are trained to watch out for things like abuse and neglect and depression. Boundaries for what volunteers are and are not expected to do are gone over. Volunteers are also told about the importance of confidentiality and the Vulnerable Adult Act.

The programs have found that the majority of their volunteers are seniors. The staff member in charge of volunteer coordinating usually matches up people with similar interests and background, or those living near each other. The director of the Merriam LAH/BNP explained that it is a "natural connection" to match up people who live near one another because they can see each other on a regular basis.

Publicity

When SE Seniors started the program was first publicized by delivering packets of information to the homes of seniors in the neighborhood. One of the main goals of publicity is to provide general awareness of the program and the services available as people are approaching the age of needing services. They put out a newsletter and instead of mailing it out, it is included in the SE newspaper so that everyone will know what is going on with the program, not just the elderly. Every once in a while they will also put an article about the program in the newspaper to keep up visibility. In the summer board members go to block parties to let people know about the services available. Representatives of the program also go to the three main seniors groups once or twice a year, and a board member goes to neighborhood association meetings to publicize the program.

Publicity for recruiting volunteers has taken several forms for SE Seniors. Mostly it has been through word of mouth and the neighborhood newspaper. Michelle noted that it is now getting harder as the pool of volunteers is getting smaller. The local churches and church groups have become the next resource for volunteers. The main modes of publicity have been through newspapers, fliers, and occasionally in church bulletins, although Michelle says that the first choice of publicity is word of mouth.

The Summit Hill LAH/BNP publishes a newsletter. Merriam also publishes a quarterly newsletter. They also recruit volunteers through word of mouth and the local newspaper work a lot with local churches. The University of St. Thomas has also been a source of volunteers for the Merriam program. The director of the Merriam program noted that often next door neighbors or others in the neighborhood are already helping out in some way, the idea is to get them "signed on to make it more formal".

Record Keeping

LAH/BNP, Inc. does not demand uniform record keeping or accounting systems, but they make recommendations as far as organizing and reporting information. They must collect inform from the different LAH/BNPs in order to report back to their funders. They do encourage the use of computers although they do not mandate it. Currently LAH/BNP is testing out a new method of organizing information via database in several LAH/BNPs. IN this database the program keeps track of clients and volunteers and what services they need and provide. Then they can cross-match clients and volunteers and keep track of who is seeing whom, and who needs to be visited by whom. Another component of the database which they hope to add to the third version of the computer software is something about coordination with local service4s. The idea is to have a record of which agencies the program is working with and what services these agencies provide.

Record keeping in the SE Seniors program takes place two ways. MVNA keeps standard nursing files for all clients who received nursing services and these are filled out by the visiting nurse. For keeping track of volunteer services, Michelle is currently

making changes to an 8-page form that is usually used. She dies require that volunteers keep track of their hours and provides space on the form for them to make comments on how the relationship is going. Sometimes volunteers find it difficult to keep track of their hours because they think if it as just helping out a friend. By asking them to report on what is going though, Michelle said she can keep up to date on what is happening with the clients and the volunteers.

The Merriam program tries to keep track of volunteer services by sending out a time sheet which asks the volunteers to record the time, date, visit types and any note on the client or the relationship. Even though, they are sent out with postage paid envelopes, the time sheets are seldom returned so staff follow-up with phone calls. As with SE Seniors, often a Merriam volunteer will feel that "This person's my friend, I don't feel like I'm volunteering anymore."

Evaluation

Along with record keeping comes evaluation of the program. The SE Seniors LAH/BNP is evaluated in a variety of ways. The nursing agency (MVNA) does an evaluation of the nursing services and the staff is evaluated by the board. Every two years a survey is sent out to client for their opinion of the services they received. According to director, Mary Quirk, the purpose of the survey is "to gage the temperature of the program".

In order to evaluate volunteer services, once a year Michelle, the volunteer coordinator, goes out to visit all of the clients (usually in the summer) and asks their opinion about how things are going. In addition, twice a year they try to have a potluck for the volunteers to get together to share concerns or talk about what is happening in their relationship with the client.

Advice

According to several representatives of the program, the success of SE Seniors is a strong board that is community led. They say that an important decision that must be made is whether the program will be board/community led or staff led. A SE Seniors board member also recommended to "draw your borders and make them clear", to define who will and who will not be served. This means physically in terms of geographic boundaries of the neighborhoods, as well as in terms of what age groups will receive services.

SE Seniors nurse Darla Wexler was initially concerned about the Logan Park and St. Anthony East desire to include young families into the program. She noted that it is easier to get funding for one specific age group. She was also concerned about a duplication of services and saw that the CHP could become "just another public health agency" because of its broad focus. When considering the CHP's goals of working with different age groups Bill Lorimer and Malcolm Mitchell mentioned something to be aware of when working with the elderly and younger residents together. According to them, the elderly have less of a preference for a lot of different people coming into their homes while younger families don't mind as much. They also feel that the elderly are more intimidated by authority figures like doctors, fire chief, or police. These are the people with power and the elderly are afraid that when they get to know them, they will see them as weak and frail and incapable of living on their own. The elderly fear that these authority figures will be able to see their limitations and try to send them out of

their homes into nursing homes. Youth, on the other hand, are very receptive to authority figures and even receive positive reinforcement form them (for example parents see the fire chief or police as good role models for their children).

Lorimer and Mitchell gave three reasons for focusing strictly on the elderly in the LAH/BNP. First, the elderly have a lot of needs. Second, it is more difficult to effectively deal with different age groups because they have different needs. Third, working with the elderly is more cost effective as the elderly have Medicare, but young people do not. Since the majority of clients have nursing services covered by the third party payer, it becomes hard for the community to shoulder the burden of paying for medical services for uninsured young people. Lorimer and Mitchell feared a possible depletion of the budget paying for nursing services to the young members of the community.

Recommendations

Bill Lorimer and Malcolm Mitchell did say that the LAH/BNP model can and should be able to approach any population and age group. I agree and feel that there are several aspects of the model which can be adapted to meet the goals of the LP-SAE Community Health Program. These aspects are highlighted below:

- The CHP should adopt a similar broad definition of health, whatever a person needs to keep them living safe and healthy in their homes. This does not necessarily mean nursing services but can include non-skilled services like friendly visiting, household chores and transportation.
- The CHP should create a volunteer orientation program, which covers similar topics as those covered in LAH/BNPs: vulnerable adults, confidentiality, and communicating with the elderly. The CHP training sessions should be expanded to include good communications techniques in general for working with all ages groups. Also the sessions should include some training on cultural sensitivity to help volunteers prepare for working with neighbors who are of a different ethnic background than themselves. A volunteer manual should be produced which gives information on the above listed topics and important phone numbers for the volunteers to know.
- The CHP should publicize in many different ways: brochures, a newsletter, and personal contact with members of the community. Representatives of the CHP should talk about the program at neighborhood association meetings, hold informational meetings in the high rise buildings, and visit other local organizations' meetings.
- The CHP should adopt a standard method of record keeping. Forms should be created to keep track of clients' needs and to have volunteers keep track of the hours they put into the program and the services they provide. It would be beneficial to create a computer database to keep track of clients, volunteers, and local service providers to aid in matching services to needs.
- The CHP should develop some sort of method of evaluating the program particularly after its first year in operation to assess the success of the program. This may be in the form of asking clients and volunteers to fill out a written questionnaire or having representatives of the program ask for feedback in person.

Stage II – Local Services

After learning about the Living At Home/Block Nurse Program model, the next step for me to take was to begin the needs assessment of the neighborhood, speaking first with representatives of local health services and social services institutions and agencies to find out what they believe to be the greatest barriers to getting health care and health needs of the residents of Logan Park and St. Anthony East. I also questioned them as to their expectations of a Community Health Program. In addition, in line with the LAH/BNP model of working with and coordinating existing services, I also inquired about possible avenues of collaboration between the CHP and these local service providers. The service agency/institution representatives I interviewed are as follows:

- Laura Lipkin, health researcher, Fremont Community Clinic
- Dr. Brian Cantor and Dr. Tom Legeros, Central Avenue Clinic
- Sue Herrig, Hennepin County Child and Teen Check-Up
- Therese Atkins, Hennepin County Community Health
- Scott Gagnon, director Logan Park Community Center
- Focus group with Pam Fitch and five family advocates at NEST (North East Strong Together)/Way to Grow
- Focus group with representatives of Webster Open School including vice-principal Ann Jackson, the school nurse, the social worker, the Native American Liaison, the African American Liaison, and a chemical abuse counselor.

Based on their professional experiences the representatives listed above identified many barriers and problems in health care that they believe are being felt by residents of the Logan Park and St. Anthony East neighborhoods. These health concerns deal with a variety of issues such as transportation, childcare, language and culture, insurance, mobility, immunizations, dental hygiene, substance abuse, mental health, educational programs, support services, and miscellaneous concerns. The different agencies also indicated possible ways that they may work in collaboration with the CHP.

Transportation

Both Laura Lipkin and the representatives from Webster School noted that transportation is a need particularly among families. Some families do not have access to transportation or limited access. It is hard to get all the children bundled up and ready to go on the bus when one child needs to go to the doctor. It is even harder when it is the parent who isn't feeling well and needs to go to the doctor. They suggest that the CHP provide transportation to and from doctors appointments, grocery stores, and pharmacies. Scott Gagnon said that although no one has specifically called and requested transportation to any of the events or programs at the park, he can see where maybe having transportation available would be nice for seniors. He suspected that a lack of transportation could be one of the reasons people are not coming to the park's community center.

Drs. Cantor and Legeros stated that transportation is important because HMOs are phasing out their taxi service to and from medical appointments and are now just giving bus fare. The bus is not always the easiest form of transportation to take so some times appointments are missed. The doctors expressed frustration at having patients schedule appointments and then not show up and not notify the clinic either. They end up wasting time and money waiting for these people when they could have been seeing other

patients. The doctors suggested several reasons for why this occurs, maybe the family does not have a telephone to notify the office that they won't be able to make the appointment, or maybe it is so extreme that their cab or ride is waiting and they are "at the house a block down smoking crack".

According to Therese Atkins and Sue Herrig there is some help with transportation for younger populations. If a person is on medical assistance or Minnesota Care and they have children, then those children are eligible through the health plan for transportation to medical appointments. A lot of health plans give out bus tokens, but if a family is pretty insistent that they cannot ride the bus (they have three other children besides the one who is sick, etc.) then they may get a taxi.

Childcare

A lack of childcare was emphasized as a large barrier to getting health care by Laura Lipkin, the Webster school focus group, the NEST group, and Drs. Cantor and Legeros. Childcare is needed in terms of taking care of a sick child while the parents are at work, taking of the other children so the parent can take the sick child to the doctor, or taking care of all the children while a sick parent goes to the doctor. Sometimes a mother or father will bring all of their children to the clinic, but then must leave them in the waiting room while only the sick child is seen. This places an extra burden on the clinic staff of having to watch the other children.

The agencies recommend that the CHP provide some sort of inexpensive childcare, because finding childcare can be very difficult. The NEST group pointed out that the age of the child matters when trying to find someone to take care of him or her, children who are potty trained and older are going to be easier to find childcare for. They point out that it is very hard to find childcare for infants and also expensive.

Language and Culture

All agencies identified language to be a barrier to getting health care. There is a huge increase in people who are not native speakers of English in the two neighborhoods. The largest populations of non-English speakers for Central Clinic are Hmong and Middle Eastern Usually Hmong patients will bring in a child to translate for them. There is a great need for interpreters. Laura Lipkin stated that Freemont clinic paid $16,00 for interpreters in the last year and most of this is not covered by insurance. There are some agencies, like Neighborhood Healthcare Network, who provide interpreters and some hospitals and clinics provide them but according to the NEST group quality is an issue. They maintain that it is hard to control the quality of the interpreters and sometimes they do not show up.

The Webster school group noted that there are many families where English is not spoken in the home. They are predominantly Hmong and Hispanic although there are also some Eastern Europeans – Ukrainians, Poles, and Russians. There are also some isolated Native Americans who are separated from the larger Indian population and some Africans, an increasing number of which are Somali. Dr. Cantor mentioned that the Africans have some ideas of parasitosis that are sometimes "tricky" to deal with. It is a different cultural background and different way of thinking. Laura Lipkin also recognized this and suggests that a lack of cultural competency is another barrier to health care. She says that Americans must understand how people not native to the United States perceive its system of health care and their own methods of health care.

Because the of differences in cultures and languages the agencies recommend that any publicity materials that the CHP may publish be in at least three languages: English, Spanish, and Hmong. The CHP should also take into account that residents will have varying reading levels and so should write their materials in a way that will be understood by a wide variety of people.

Both the Webster school and NEST groups pointed out that some Hispanic families in the neighborhood are undocumented or illegal residents of the United States and so cannot apply for medical assistance or insurance. In actuality, according to Sue Herrig and Therese Atkins, there is some assistance for undocumented residents though it is limited. Undocumented children can get ongoing medical assistance care. Also many undocumented parents have children born in the United States, and those children are eligible for Minnesota Care. In the case of an emergency, undocumented adults may receive assistance from the county and pregnant women can get help also. Many times undocumented residents either do not know about these options or choose not to use them because for fear of being caught. Atkins and Herrig also pointed out that some non-English speaking immigrants have access to health insurance through their jobs but do not know because their employers do not tell them or they do know but no one will explain to them how to go about using it.

Insurance

Although they don't come strictly from Logan Park and St. Anthony East, about one third of the Central Ave. Clinic's patients are not insured. Drs. Legeros and Cantor say that many of them actually qualify for Minnesota Care and should be getting it but don't want to. They either distrust the system or cannot make a payment fee. Sue Herrig ran across this in Logan Park where some families who are getting low or no wages are being asked to pay $300-$400 in insurance premiums are opting not to pay. The doctors and the Webster School group both agreed that many times people just get fed up with all of the run around associated with the insurance system and just give up the whole process.

The NEST group expressed the concern that many times mothers and children will qualify for medical assistance but the fathers will not and so will not be insured. The fathers do not know where to go or what to do to get insurance. The NEST group also noted a lack of education about insurance and the whole process. They suggest that it would be helpful for the CHP to not only provide insurance forms but to also give assistance on how to fill them out.

Mobility

Therese Atkins and Sue Herrig noted that mobility is a real problem as far as access to health care is concerned. They stated that many poor families are often moving and are chronically stressed. Each time they move the ten takes a while to settle in and find a clinic or doctor. The Webster school group also pointed out that single parents sometimes move around so much that they cannot build relationships or a network of friends who can give them advice or answer questions. They then feel like the problems they encounter are only happening to them.

This mobility and lack of contact with doctors and clinics translates into poor prenatal health care and sometimes missed immunizations for children. When working with the WIC families who come to Logan Park, Sue Herrig noticed that some of those children seemed to be missing immunizations. The families seemed to be fairly transient, perhaps the parents had split up and all of a sudden the children ended up at their grandparents in another town. Perhaps the children did not have the actual immunizations or maybe they just did not have access to the records.

Immunizations

In terms of keeping up with immunizations, Sue Herrig found that a lot families in these neighborhoods are up to date. There are a number of reasons for this. Often times in order to enter Head Start, day cares, preschools and public schools the child must be up to date on their shots. The varying agencies will demand that they be up to date. All students must be immunized before starting school. This was a new rule implemented last year – no shots, no school. At many schools, if children showed up at school, whether it be kindergarten to 12th grade and they do not have their immunizations up to date they are sent home. They were very strict about it. Webster open school started providing immunizations at the school at the beginning of the year. Sue Herrig predicts that over the course of time, as the rule is implemented, there will not be a whole lot of children that are not immunized.

The NEST group noted that some families, for whatever reason, are resistant to having immunizations done. Also, as was mentioned earlier, many families are moving around and neglect to have their children immunized. They also brought up the fact that immunization scheduling by clinics is not on track so that some of the immunizations are considered invalid and they have to be repeated. For example, if you are supposed to have a six month immunization, and the clinic offers it at five months, then the series is considered "out of sync". Also a lack of insurance was mentioned in contributing to missing immunizations, because some insurance or medical assistance policies cut off at two years old, and immunizations or any health care past that age will not be covered.

Dental Hygiene

Dental care was indicated to be a problem by the Webster School and NEST Groups. The Native American liaison at Webster School had noticed some of the Hispanic students do not have especially good dental care or do not appear to receive any dental care at all. They "just have little stubs in their mouth". The NEST group pointed out that many dental offices take only new patients and most require medical assistance. There is no preventative efforts for dental care (tooth sealing, etc.). Many dental offices demand full payment, cash up front before any work is done if the patient has no medical assistance. There is no kind of payment plan.

Substance Abuse

The Webster School group and Sue Herrig and Therese Atkins indicated that substance plays a large role in health care problems among families. Those children in homes where parents are chemically dependent tend to be the ones who fall through the cracks, who do not get their visits to the doctor and immunizations. Sue Herrig notes that alcohol and methanphetamines are the drugs of choice in the Logan Park and St. Anthony

East neighborhoods; she is interested in helping with chemical dependency issues but she herself doesn't know where to start or how to find out about those with substance abuse problems.

Drs. Legeros and Cantor indicated that for the people they see who are under 40 years old, they estimate that about half the time there is a history of substance, sexual or physical abuse. The substance abuse usually started out as heavy use when the people were younger, then as they got older it shifted to no use or sporadic use. However, since all that time in their youth was devoted to drugs there was no building up or resources, saving money, getting an education, so now they are having problems and they have families with problems (e.g. teen pregnancy, family members in jail).

In terms of treatment of chemical health problems, Sue Herrig indicated that having a straight friend or relative to make sure the health of his or her children was being taken care of makes a huge difference for someone with a substance abuse problem. Although this straight person was usually resented or hated for being a nag, they still had a big influence and provided a sense of stability. Often when the parent brought a child to a clinic it was the straight friend that they wrote down as the person to contact in case of emergency.

Mental Health

According to Dr. Cantor, the most loyal patients are those who are depressed. He sees many men in their middle ages (45 years old and up) who suffer from depression. When they were younger they drank or did drugs to counter the depression without really knowing that is what they were covering up. Now that they are not drinking or doing drugs as much, they are having a hard time finding ways to deal with their depression. The doctors help them get on medication, Dr. Cantor sees a great need to help them with their self esteem. The need is large but both Dr. Cantor and Dr. Legeros think a community health program could help fill it. Dr. Cantor thought this would be a key group to try to educate with a meeting.

Educational Programs

Several agencies noted that educational programs would be a good idea in promoting good health in the neighborhoods. Dr. Cantor used to hold a program that focused on a "disease of the month" where people could get together to learn more about a particular disease. He found that in this area, however, people do not come to group meetings, at least not those people who need the information the most. He wasn't reaching the people he wanted to most so then began thinking that a big problem among low income people is that they feel they have no stake in society. He stated that these people need to be shown that someone cares about them and their health and that they should too. When it comes to educational programs the doctors have found that one-on-one interaction usually works better than group interaction for the elderly. Young people, they feel, would probably like to sit down and talk about things together, more of a group environment. They maintain that education programs are a lot about building community. They require person-to-person contact because sometimes you just have to keep on people to do things. The doctors gave an example of giving safety latches and outlet covers to head start families one year. When they checked the next year, the latches and outlet covers had not been used. They next year they actually arranged for people to go into the homes with screw drivers and show parents how to install them

themselves. An incentive was needed, and in this case the incentive was the empowerment the families gained by doing things themselves.

The Webster School group also suggested a need for in-home health education. They indicated that topics like head lice, organizational skills, dental services, meal planning, nutritional advice, chemical dependency, safety checks, insurance and medical assistance information could all be addressed in visits to residents' homes.

Support Services

Laura Lipkin pointed out that low income patients require more "social supports" than other patients who have more money. When someone does not have enough money, they do not need just medical care but a whole host of other things including medical assistance, a sliding fee scale, transportation, childcare, chores, and companionship.

The Webster School group identified a number of support services the CHP could provide. The recommend that the program let people know where to go for help, referrals, help them fill out insurance forms, and make them aware of the options they have even if they do not have much money. They need to be made aware that other options exist out there. They recommended providing single parent support systems like establishing some kind of help line for single parent s so that they can get advice, answers to questions and the piece of mind that they aren't alone, that the problems they might be having don't only happen to them. They also suggest some kind of advocacy program so that single parents could talk with other parents or people who know what they are going through. Several in the group suggested that it would also be nice to for children to have an adult they can go to for advice, to ask questions of, and to have someone who will listen when there is no one at home who will.

Drs. Legeros and Cantor suggested that the CHP might be helpful in a follow-up capacity after clinic visits. They expressed that "the biggest problem is that we don't have anyone who, after we see them, can go to their homes to check out and make sure they are doing what we told them to do."

Miscellaneous Services

A few other health related needs or problems were mentioned by some of the service agencies. These needs range from exercise to sexual abuse to family planning and more. Scott Gagnon said that he would like to get some kind of senior exercise program going whether it be opening up the gym in the winter for them to walk or having more formal senior exercise classes.

The Webster School group revealed that they have a higher than average number of cases of head lice and it is recurrent, instead of being treated. They also said that they felt there is a very weak referral service in this area – no free and very limited low cost medical services and there was only one clinic who volunteered to give free immunizations (Fairview).

According to the NEST group, lead in the household is a big health problem. A lot of families are living in houses with lead and there is a need for preventative education about lead. NEST has a grant to help the lead problem but it only lasts through June. Families need help cleaning the house; they need that hands-on help with someone there going through every room to make sure they really follow through with removing the lead.

Family planning is an issue that isn't touched much at NEST. There is a need to educate neighborhood residents about STDs and AIDS. The NEST group also indicated that car seats can be a problem. Either families cannot afford to buy a car seat, or they do not use it, or they do not know how to properly install and use it.

Also according to the NEST group, the Sheridan Women's and Children's clinic is currently full. A person cannot get help there unless they are specifically assigned to it by some agency. This creates a problem because Sheridan is one of the Fremont Community Clinics, which are the only clinics in this area who serve uninsured patients and offer a sliding fee scale.

Collaboration

In line with the Living At Home/Block Nurse Program model a key aspect of the Logan Park-St. Anthony East Community Health Program needs to be working in collaboration with local service agencies without duplicating services. The representatives of the services agencies with which I spoke indicated several ways that they are willing to work with the CHP.

Webster Open School – All of the members of this focus group were very interested in the program and would be willing to contact the program with referrals once the program is put into place and services are being provided. They said that it would be nice to have a place to refer people to.

Scott Gagnon, Logan Park – Logan park is willing to help in promotion of any health related activities by writing about them in their fliers. Fliers are posted at the Community Center desk and sometimes taken to schools. The Community Center facilities are also available for meetings and events. The CHP will need to call ahead to reserve space. Scott does not track the health needs of families or people coming into the center, but would be willing to work with the CHP if they wanted to keep track of injuries or illness that they encounter. Most of the injuries they run into are bumps on the head or scraped from falls on the ice or the playground. The Community Center gets its first aid supplies through the park board so those needs are provided for. Scott and one other staff member had first aid training, but would appreciate first aid training for his fifteen part-time staff members if the program were to provide it.

NEST – Pam Fitch and the other NEST family advocates invite a LP-SAE CHP staff person to attend their community partners meetings. The meetings occur once a week and are attended by representatives from different service organizations in the community. The meetings provide a place for networking and inter-agency contact and communication. NEST is looking for and willing to do some kind of intergenerational events. The group said they would be willing to refer a family to the CHP, but in to do so, it would have to be with the family's consent. In many cases they have a consent form that the family members sign saying that the NEST case worker can talk to other service agencies (such as the clinic or the school) about the client. They would expect that if they were to refer a client to us it would be the client's initiative to call the CHP for assistance, but they could also call us with the consent of the client. By the same token, any families we would refer to NEST must have given their consent for us to do so.

Sue Herrig, Hennepin County Child and Teen Check-Up – Sue indicated that she would be willing to refer people to the program and asks that she be informed as to what services are being provided. She said the NEST/Way to Grow seems like the most obvious place for her to refer people, but suggests that the CHP do something that NEST does not, like provide transportation, instead of duplicating services. Child and Teen Check-Up would also be willing to provide some education materials for the CHP to distribute.

Therese Atkins, Hennepin County Public Health – If the CHP identifies people without insurance, Therese would not mind if we sent them her way. However, she would like to have her agency train CHP employees to help people fill out Minnesota Care insurance forms and then have the CHP look to the Public Health as a referral source if a family asks a question that CHP staff cannot answer.

Dr. Brian Cantor and Dr. Tom Legeros, Central Avenue Clinic – The doctors mentioned that a way in which the CHP could help their work is to provide follow up for the patients once they leave the clinic. Both doctors said they can and will do everything they can for the patient while he or she is in the clinic, but once the patient leaves they cannot do anything. They would appreciate someone to be there to provide that follow up, whether is it something like a weight loss program, a stop smoking program, of following a health plan. The doctors suggest that maybe someone from the CHP (a volunteer) could call or visit the patients to make sure they are keeping on track. The doctors suggest that other ways to help could be to make sure patients are following their medication schedule, make sure they have proper nutrition ("even go into their kitchen and snoop in their cupboards to make sure they really have food and that it is healthy"), make sure they are following their exercise programs, to provide companionship, and to provide respite care for family members caring for an ill person.

Drs. Cantor and Legeros pointed to another problem which occurs in that due to health problems people cannot work and then lose their homes or lease or mortgage. They cannot make rent payments, get evicted and have no place to go. Or, maybe the land lord where they live will not keep up with repairs or maintenance and the conditions in which a person lives is contributing to their poor health. The doctors suggest that some form of advocacy be performed on behalf of people in these situations and propose the creation of something like a first call for help for legal problems.

Dr. Legeros is willing to help the CHP set up a sliding fee scale when the time comes. The sliding fee scale that the clinic uses is based on the federal poverty standards. There is a grid set up and, based on where a person falls within that grid according to their income level, that determines what percentage of the payment they will have to make. The same grid can be used for the CHP and a billing sheet will be set up for the nurse according to what services will be provided. Every service will be listed on the billing sheet with a cost assessed to it. The nurse will keep track of the services used by the patient and then the program can check it against the scale to determine what percentage of the total cost the patient will have to pay. This is for people who do not have insurance or whose deductible is too high to be able to pay for these services.

A foot clinic is something that Dr. Cantor had done in the high rise buildings in the neighborhood in the past, but he had to discontinue the service because it was being done for free and he couldn't fund it any longer. He would like to start the foot clinics up again and is looking to the CHP for possible assistance in funding the service.

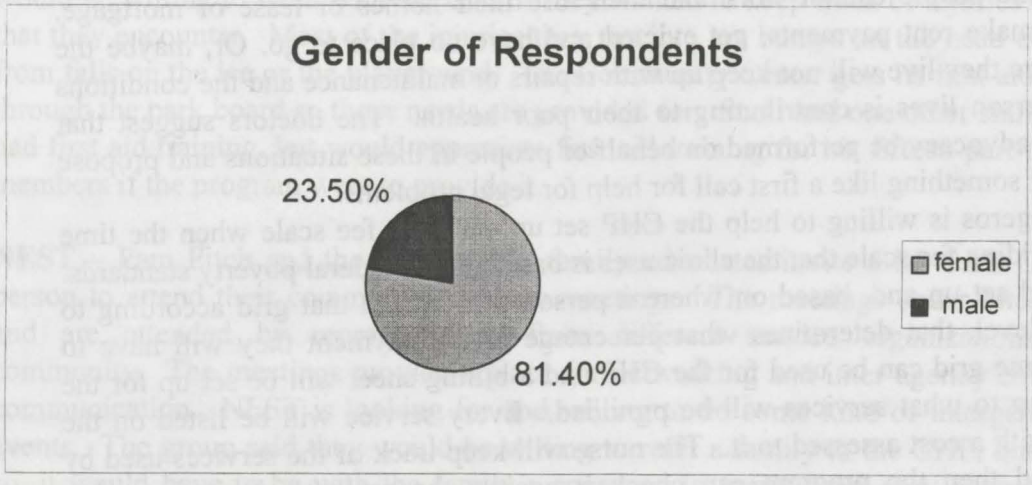
Stage III – The Neighborhood

The Survey

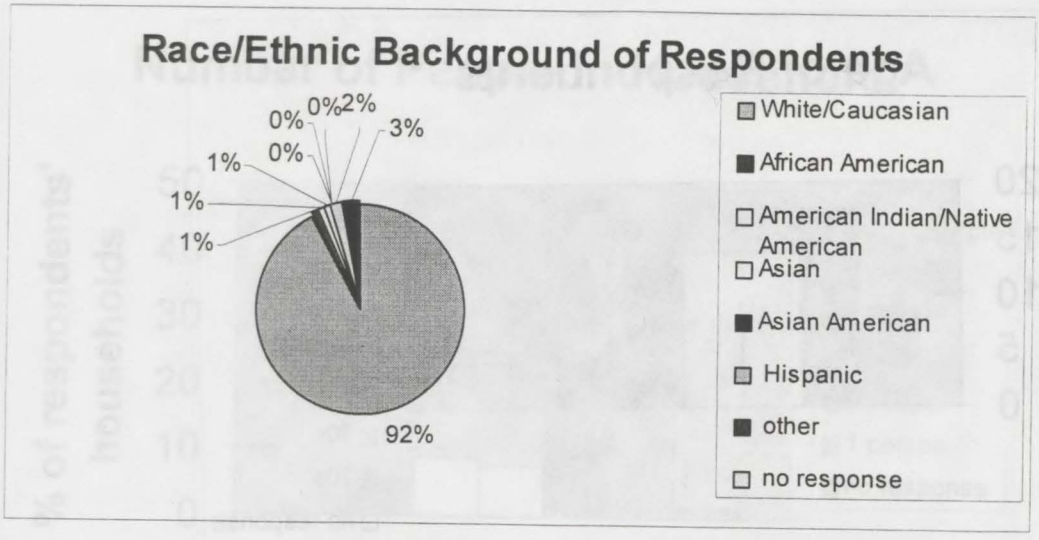
In an effort to assess the health needs as well as the interest level of the community in the Community Health Program a survey was distributed to the residents in the Logan Park and St. Anthony East neighborhoods. (For the complete survey see Appendix 2) A total of 1,163 surveys were distributed in the neighborhood by two families from the neighborhoods who do similar types of distributing of neighborhood association newsletters and announcements. The surveys included a self addressed, postage paid return envelope. The number of surveys returned to NESCRC was one hundred and two (102). Clearly a less that 10% response rate is not statistically valid, but the returned surveys do give some interesting information about what's going on in our neighborhoods. Also, the survey serves as not just a way of assessing the needs of the neighborhoods, it is also a means of publicity for the program and a tool for recruiting both clients and volunteers. The survey questions can be divided into three parts: demographics, health service access, and program services.

Demographics

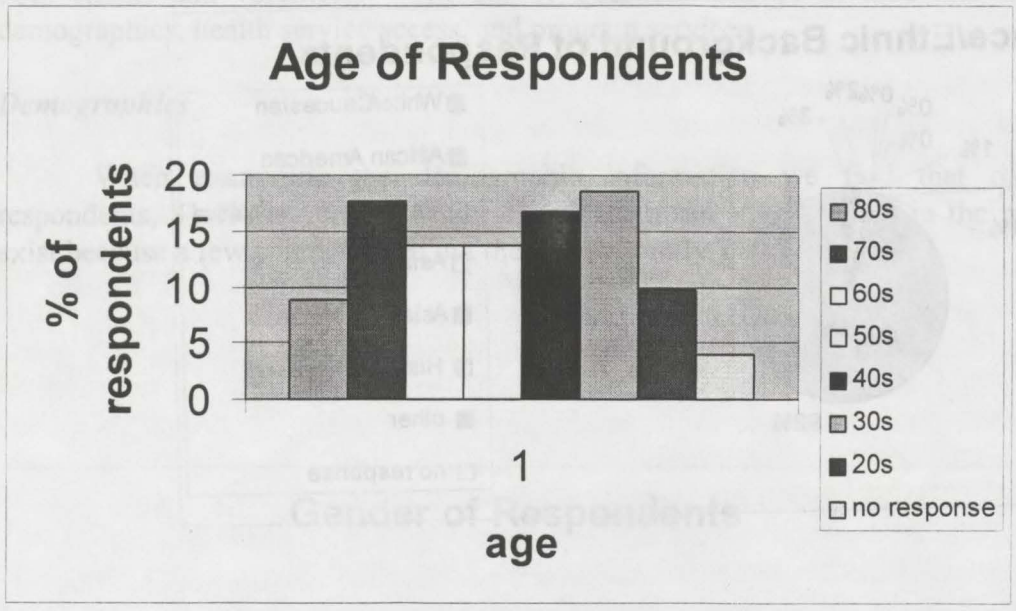
When examining the demographic information we find that of the 102 respondents, 81.4% are female while 23.5% are male. (An overlap in the percentages exist because a few couples filled out the survey jointly.)



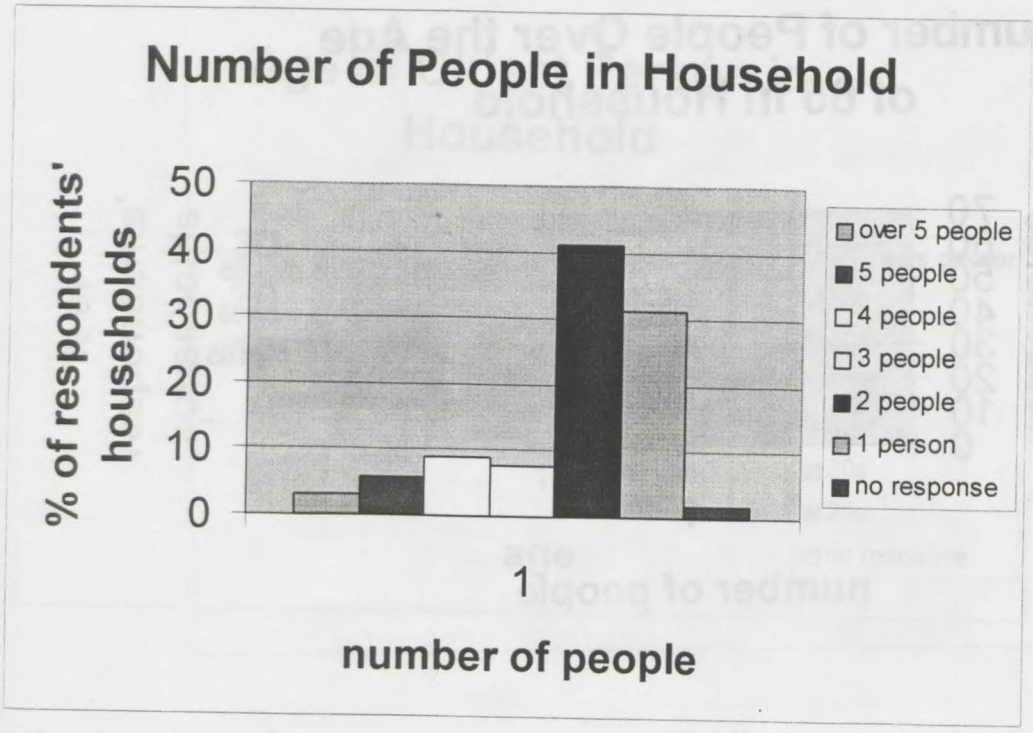
The majority of respondents are White/Caucasian, 95.0%. One percent (1.0%) of respondents are African American, 1.0% are American Indian/Native American, and 1.0% are Asian. Two percent (2.0%) of respondents classified themselves as "Other"; one specified "human" while the other wrote in "European American". Three percent (3.0%) gave no response when asked to indicate their race or ethnic background.



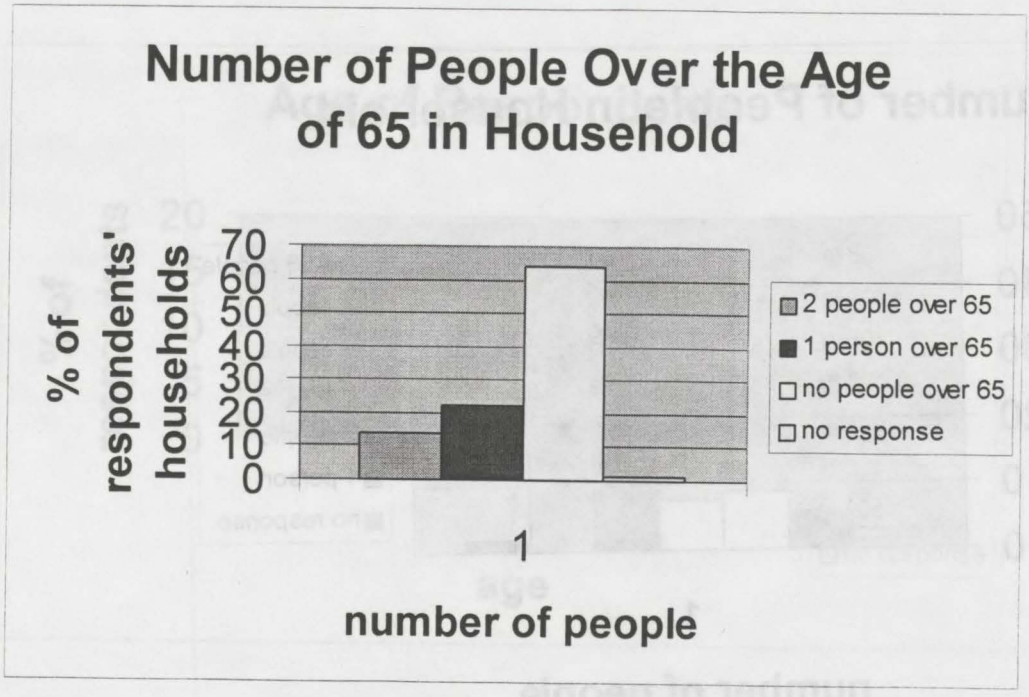
It is interesting to note that the respondents are fairly evenly distributed in regard to their ages. The majority (at only 18.6%) were born between 1960 and 1969 and so are in their thirties. The fewest number of respondents (9.8%) are in their 20s. Results indicate that 8.8% of respondents are in their 80s or older. Those born in the 1920s (those in their 70s) make up 17.6% of the respondents. Two age categories, those in their 60s and those in their 50s, each include 13.7% of the respondents. Those respondents in their 40s make up 16.7%, and 3.9% of respondents declined to state the year they were born. For more detailed information on the years in which the respondents were born see Appendix 3.



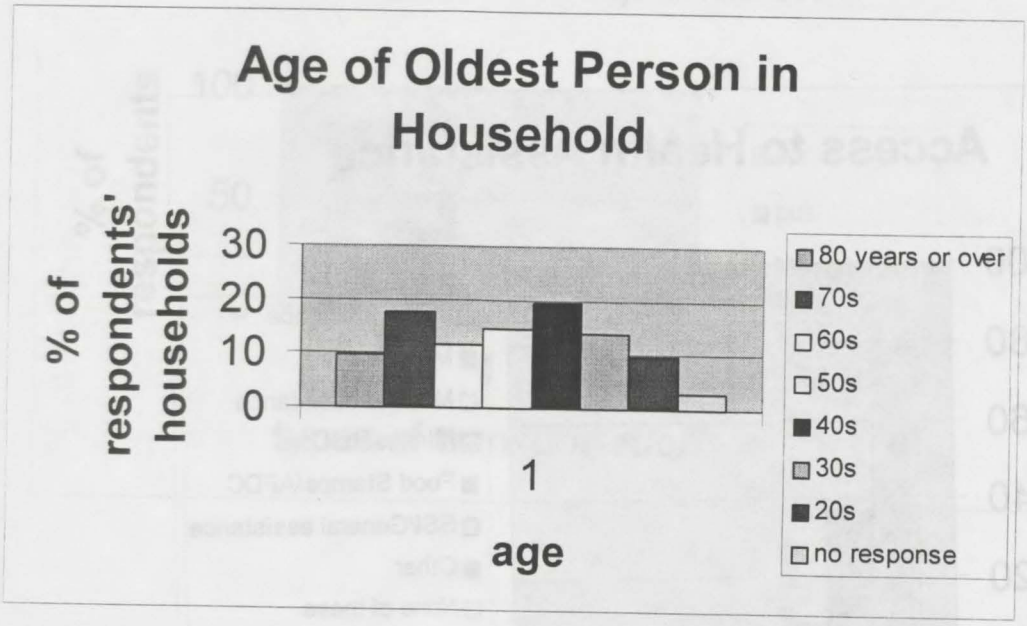
The results indicate that the most respondents come from fairly small households. The majority of respondents (41.2%) are living in households with two people. The next highest percentage are those respondents living alone at 31.4%. 8.8% of respondents are living in households of four, and 7.8% of respondents are living in households of three. The percentage of respondents living with four other people, making up a household of five, is 5.9% Three percent (3.0%) of respondents are living in households of over 5 people. This includes one household of eight, one of seven, and one of six. 1.9% of respondents did not indicate how many people are in their household.



Survey results indicate that the majority of respondents (63.7%) do not have someone over 65 years old living in their household. 36.3% of respondents do have someone 65 years or older living in their household. 13.7% of respondents' households have two persons 65 years old or over and 22.6% have one person 65 years old or over. One percent (1.0%) gave no response to this question.

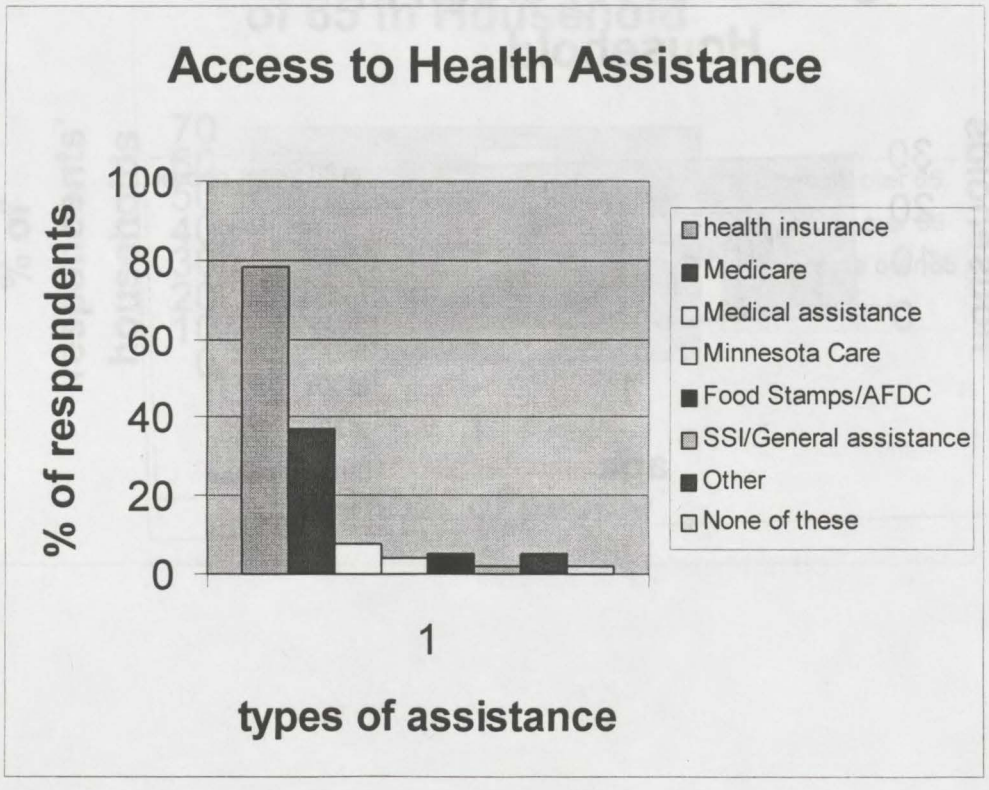


In 9.8% of respondents' households the oldest person is over 80 years old. In 17.6% of households the oldest person is in their 70s. The percentage of households where the oldest person is in their 60s is 11.8%. Likewise, those households where the oldest are in their 50s is 14.7%. Those in their 40s, at 19.6%, make up the largest number of the 'oldest' group. In 13.7% of households the oldest person is in their 30s and in 9.8% of respondents' households the oldest person is in their 20s. Three percent (3.0%) gave no response to this question. More detailed information on the ages of the oldest members of respondents' households can be found in Appendix 4.

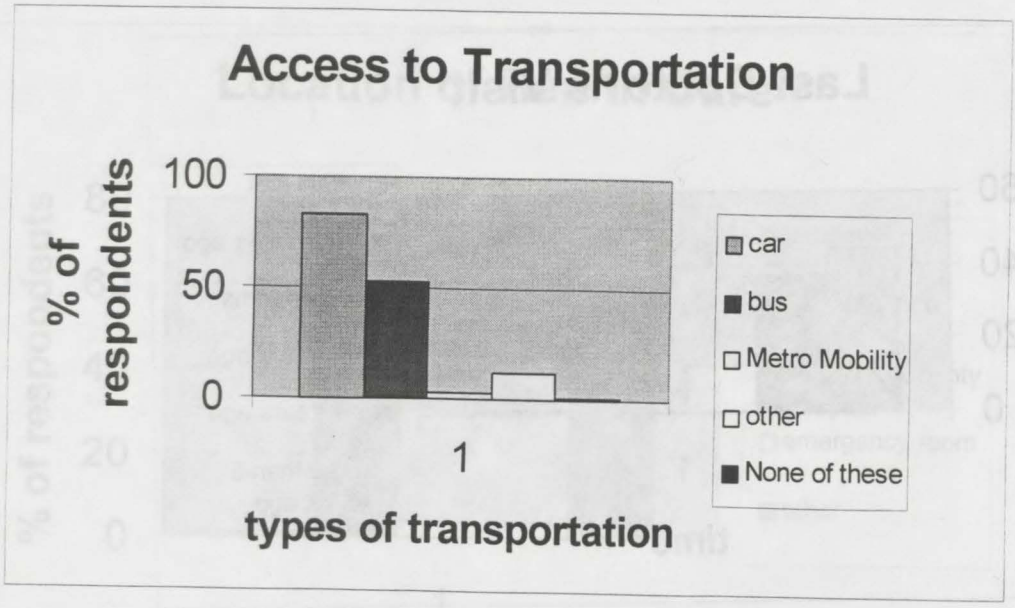


Health Services Access

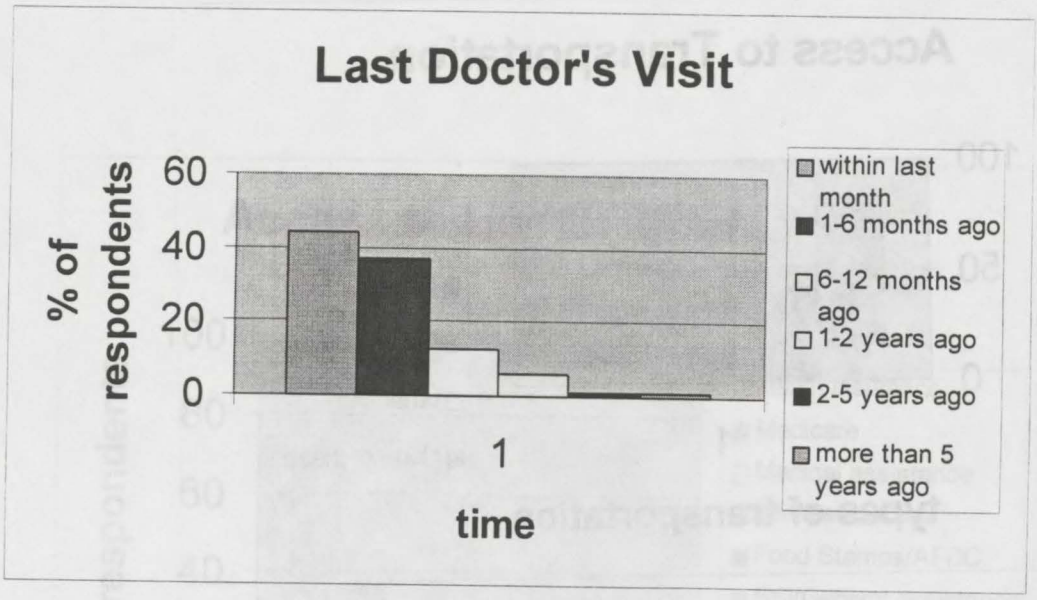
When asked whether they or members of their household have insurance, Medicare, medical assistance, or some other form of health care assistance, the majority of respondents (78.4%) indicated that they have health insurance. 37.3% of respondents are on Medicare. 7.8% of respondents indicated that they are on medical assistance and 3.9% are enrolled in Minnesota Care. 4.9% of respondents replied that they use food stamps or AFDC; and 2.0% indicated they are on SSI or General assistance. 4.9% of respondents specified other health care insurance or assistance, including Medica, Senior Partners, Long Term, and Blue Cross. 2.0% of those surveyed responded that they have none of the above types of health care assistance.



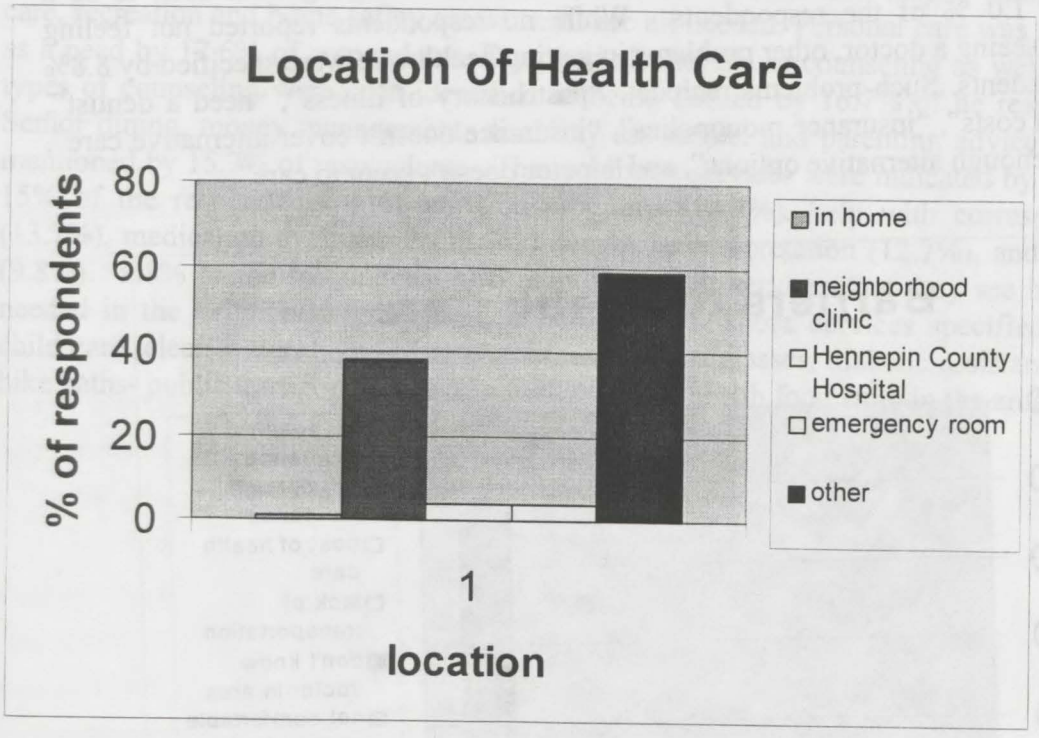
When asked about the types of transportation they or members of their household use, the majority of respondents (83.3%) said they use a car. 52.9% of respondents also indicated that they can use the bus. 2.9% of respondents use Metro Mobility. Other types of transportation were specified by 12.4% of respondents. The other modes of transportation mentioned were usually bikes and walking, although "volunteer driver", "daughter and granddaughter", "car with driver", "family sometimes", and "private medical transportation" were also given as responses. One percent (1.0%) of respondents indicated that they do not use any of the above mentioned types of transportation.



The majority of respondents have seen a doctor in the past year. Nearly half of the respondents (44.1%) have visited a doctor within the last month. 37.2% have visited a doctor one to six months ago. 12.7% of respondents have seen a doctor six to twelve months ago. Of the respondents who have not seen a doctor in over a year, 5.9% visited a doctor one to two years ago, 1.0% visited one between two and five years ago, and 1.0% has not visited a doctor in over five years.

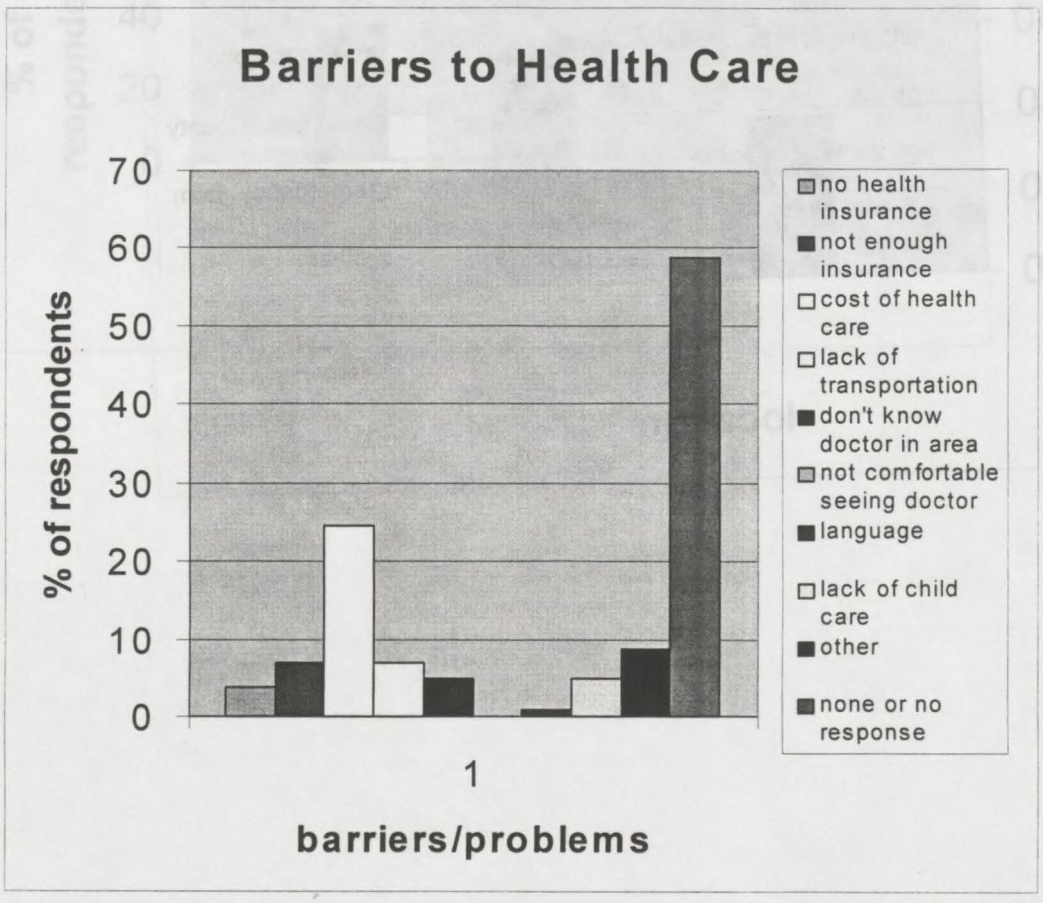


The survey results indicate that residents of Logan Park and St. Anthony East are receiving health care from a variety of sources. When asked where the respondents get their health care, only 1.0% responded in their homes. 38.2% indicated that they receive health care at a neighborhood clinic (for a list of the those clinics specified as neighborhood clinics see Appendix 4). The Hennepin County Hospital Clinic and the emergency room were each sources of health care for 3.9% of respondents. Over half of the respondents (58.8%) specified other locations where they receive health care (for a complete list of those clinics specified under "other" see Appendix 5).



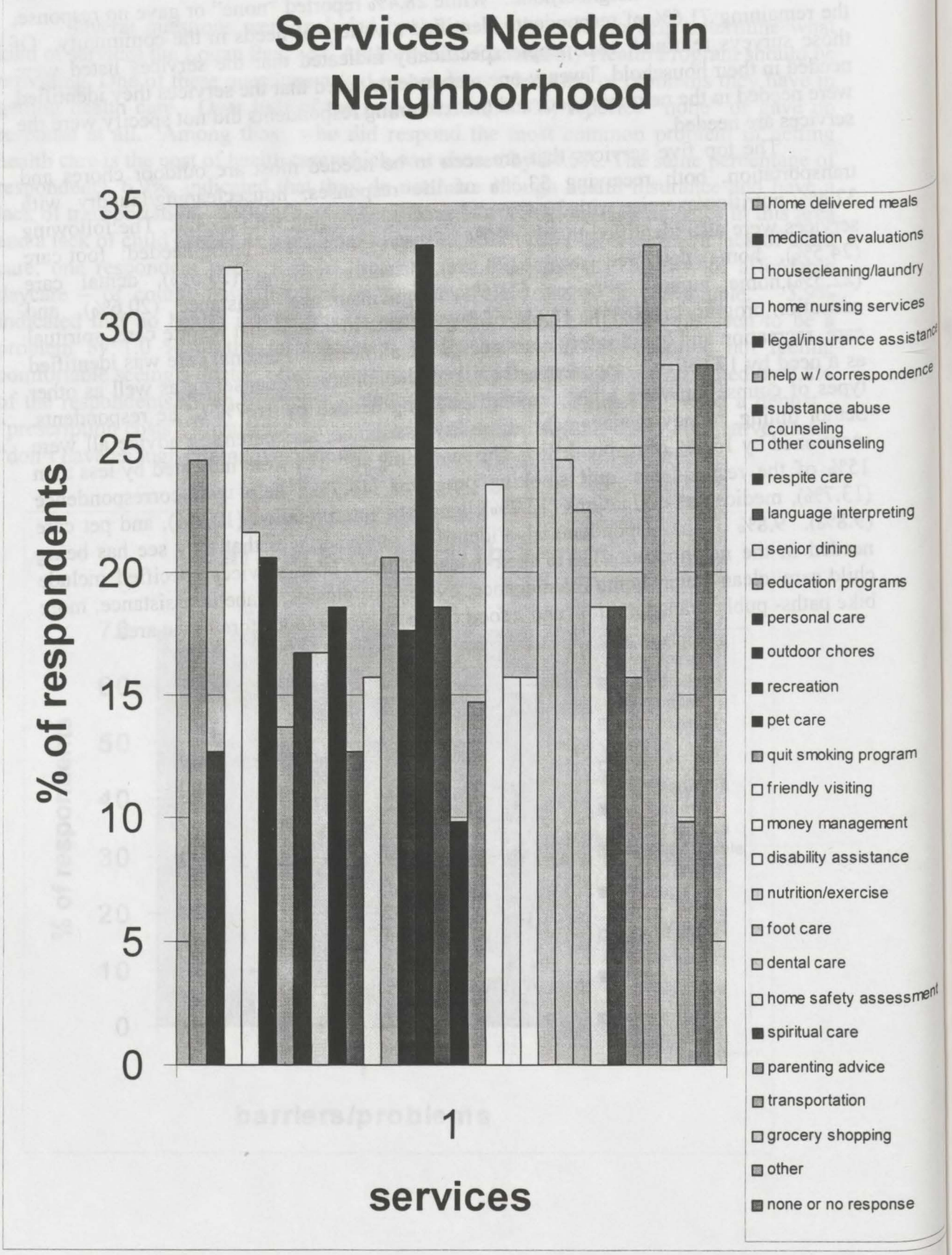
Program Services

Several questions were included in the survey in order to help determine what kind of services the Logan Park –St. Anthony East Community Health Program should be providing. One of these questions asked respondents what kind of problems they have in getting health care. Over half of the respondents (58.8%) reported "none" or gave no response at all. Among those who did respond the most common problem in getting health care is the cost of health care which was chosen by 24.5%. The same percentage of respondents, 6.9%, indicated that they do not have enough health insurance and have a lack of transportation. 4.9% of respondents found both not knowing a doctor in this area and a lack of child care to be a problem in getting health care. In reporting a lack of child care, one respondent wrote that he "recently lost [his] job due to lack of affordable daycare – of course now that I'm on assistance day care is now available." 3.9% indicated that no health insurance is a problem for them. Language was seen to be a problem by 1.0 % of the respondents. While no respondents reported not feeling comfortable seeing a doctor, other problems in getting health care were specified by 8.8% of the respondents. Such problems include: "past history of illness", "need a dentist", "prescription costs", "insurance monopolies", "insurance doesn't cover alternative care", "don't have enough alternative options", and "doctor doesn't seem to care".

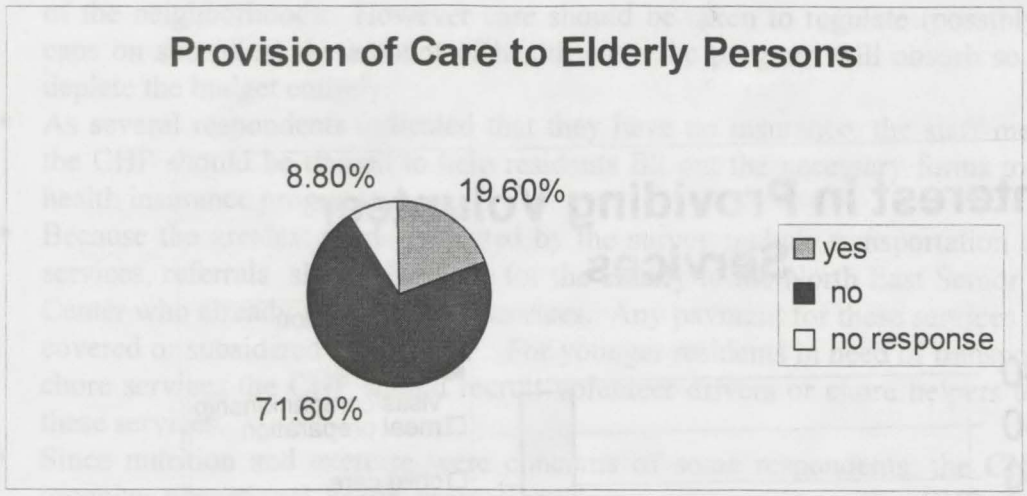


Survey respondents were asked to identify several services they feel are needed in their households or neighborhood. While 28.4% reported "none" or gave no response, the remaining 71.6% of respondents identified a variety of needs in the community. Of those surveys returned, two people specifically indicated that the services listed were needed in their household. Twenty-one respondents noted that the services they identified were needed in the neighborhood, and the remaining respondents did not specify were the services are needed.

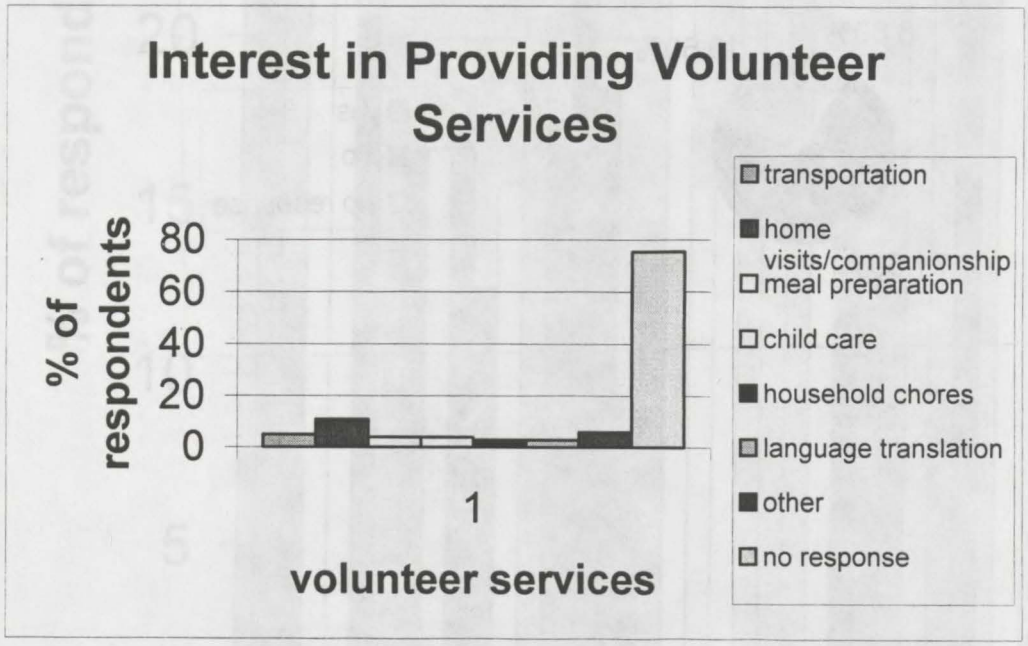
The top five services that are seen to be needed most are outdoor chores and transportation, both receiving 33.3% of the responses; housecleaning/laundry with 32.4%; nutrition/exercise with 30.4%; and grocery shopping with 28.4%. The following services were also identified by over 20% of the respondents as being needed: foot care (24.5%), home delivered meals (24.5%), friendly visiting (23.5%), dental care (22.5%),home nursing services (21.6%), legal/insurance assistance (20.6%), and education programs (20.6%). 18.6% of respondents indicated that respite care, spiritual care, recreation and home safety assessments are all needed. Personal care was identified as a need by 17.6% of respondents. Drug and alcohol abuse counseling as well as other types of counseling were both identified as being needed by 16.7% of he respondents. Senior dining, money management, disability assistance, and parenting advice all were mentioned by 15.7% of respondents. The remaining services were indicated by less than 15% of the respondents: quit smoking programs (14.7%), help with correspondence (13.7%), medication evaluations (12.7%), language interpretation (12.7%), and pet care (9.8%). 9.8% of the respondents also identified other services that they see has being needed in the neighborhood or in their households. Those services specified include child care, clean water, home maintenance, eye exams/glasses, diabetic assistance, more bike paths- public transportation, and a food co-op or health food store in the area.


Services Needed in Neighborhood
% of respondents
35
30
25
20
15
10
5
0
1
services
home delivered meals
medication evaluations
housecleaning/laundry
home nursing services
legal/insurance assistance
help w / correspondence
substance abuse counseling
other counseling
respite care
language interpreting
senior dining
education programs
personal care
outdoor chores
recreation
pet care
quit smoking program
friendly visiting
money management
disability assistance
nutrition/exercise
foot care
dental care
home safety assessment
spiritual care
parenting advice
transportation
grocery shopping
other
none or no response

Because the Community Health Program should focus on neighbor helping neighbor, the survey sought to assess how many residents are currently taking care of an elderly person be it parent, spouse, relative, or friend. The results indicate that 71.6% of the respondents currently do not provide care for an elderly person, while 19.6% replied that they do. 8.8% gave no response to this question. For those who do provide care to an elderly person, this care takes many different shapes. The following are examples of care specified by the survey respondents: "general support", "we try to help each other", "help two of my sisters with a 92 year old mother", "yard-house upkeep", grocery shopping, house cleaning, transportation, friendly visiting, "I look in on some elderly people to visit", spiritual care, "some ESL (English as a second language) to building and neighborhood Russians", "take care of his yard, snow and mow", "visit parent once per month".



In an effort to identify potential volunteers for the Community Health Program the survey included a question asking residents to indicate whether they are interested in providing any volunteer services. While 75.5% of respondents gave no response to this question, 24.5% did indicate they would like to volunteer in a variety of ways. The majority of potential volunteers indicated that they would be interested in providing home visits and companionship (10.8%). The survey results indicate that 4.9% are interested in providing transportation and both meal preparation and child care received 3.9% of responses. 2.9% of respondents were interested helping with household chores. Three people (2.9%) indicated that they are interested in providing language translation, two who speak Russian and one who speaks Japanese. Other types of services were specified by 5.9% of respondents. These services include meals on wheels, participation on the CHP steering committee, grocery buying, shiatsu therapy, youth health education programs, and outdoor chores. One respondent even offered the services of her dog writing,"we have a retired greyhound who is terrific at visiting young and old alike at rest homes or whatever."



Recommendations

Based on the survey responses, I feel the following recommendations should be taken into consideration by the LP-SAE CHP when implementing services:

- Since lack of child care was indicated to be a problem in getting health care for some residents, the CHP should recruit volunteers to perform child care in their own home or the homes of the clients. The services should be limited to health needs, however, and care should be taken not to become a child care service. It would be beneficial though to provide child care for a sick child who cannot go to school and who's parents cannot afford to stay home from work, for a child or children who's parent is sick or who needs to visit the doctor, or for healthy siblings while a parent takes a sick child to the doctor. Also a "Parents Night Out" may be provided where volunteers will watch a group of children while their parents attend an educational class or just have a night of relaxation.
- Since cost was indicated to be a large barrier to health care the CHP should establish a sliding fee scale to help defray some of the costs of medical services for residents of the neighborhoods. However care should be taken to regulate (possibly through caps on subsidies) the amount of health costs the program will absorb so as not to deplete the budget entirely.
- As several respondents indicated that they have no insurance, the staff members of the CHP should be trained to help residents fill out the necessary forms to enroll in health insurance programs.
- Because the greatest needs indicated by the survey include transportation and chore services, referrals should be made for the elderly to the North East Senior Resource Center who already provide these services. Any payment for these services should be covered or subsidized by the CHP. For younger residents in need of transportation or chore services the CHP should recruit volunteer drivers or chore helpers to provide these services.
- Since nutrition and exercise were concerns of some respondents, the CHP should organize educational health promotion classes on nutrition. The CHP should also look into the creation of a seniors exercise class at Logan Park, where seniors can come and learn low impact exercises to keep themselves fit.
- Since several residents indicated that they do take care of an elderly person, the CHP should try to identify those individuals and encourage them to keep up their work. The promotion of the CHP should help residents to realize that this is just what is meant by neighbor-helping-neighbor.
- The CHP should contact those respondents who indicated that they are willing to volunteer for the program as soon as possible to match them up with clients in the neighborhood who need services. A database should be created to keep track of the person and the volunteer services they are willing to provide. Those individuals who indicated that they are willing to serve as Russian translators should be connected to the high rise buildings who are in need of Russian translators.
- The CHP should put the names of those respondents who gave them on a mailing list and contact them directly to let them know what services are being provided and to recruit volunteers.

The Neighborhood: High Rise Results

In conjunction with the survey, interviews and focus groups also took place with residents of both the St. Anthony East and Logan Park neighborhoods to assess their needs and expectations for a community health program. For interview and focus group purposes the neighborhoods were divided into two distinct populations: those living in high rise apartment buildings and those living in their homes.

Interviews and focus groups took place in two high rise buildings, 1717 Washington Ave. and 828 Spring Street. The meetings in the high rise buildings took place prior to the distribution of the survey for two reasons: 1) few high rise residents would actually be receiving the survey and 2) the high rise residents are somewhat contained populations themselves and it was easier to gain access and identify people with whom to speak. Focus groups were especially applicable for high rise buildings because there is space for the residents to gather in a central location. Approximately 25 high rise residents were consulted, the majority of whom were female over the age of 60, and two members of the high rise counseling staff. The results of these meetings led to a number of health related problems or needs being identified. The following is a summary of those needs and some recommendations for meeting them where possible.

Foot Care

Needs/problems

- Foot care is an important need in the buildings as the elderly get less flexible with age; and arthritis or other health problems prevent them from being able to reach their feet to take care of trimming nails, etc.
- Foot care is needed for diabetics whose legs and feet swell. Diabetics also need to find shoes that are comfortable and also provide support for their arches and ankles. Support for ankles is also helpful for all older adults who are unstable walking.
- Residents must wear shoes because they have poor circulation and cannot risk getting a wound in the foot which will not heal. For some, stepping on the smallest thing cause a great deal of pain. Others could step on a tack or staple and not feel it and then would not seek any first aid treatment if there is a wound.
- Special shoes are expensive and hard to find. There needs to be some way to find out how to get special shoes as well other disability equipment at reasonable prices like walkers, canes, and wheelchairs.
- There is no one coming into the building to provide foot care. A doctor who used to come some years ago stopped.

Recommendations

- Dr. Brian Cantor at the Central Avenue Clinic has indicated that he would like to continue a foot care clinic for the high rise buildings but needs financial support. The CHP should consider funding this service and contact Dr. Cantor to look into starting the foot care clinic again.
- The CHP should consider having the visiting nurse perform foot care to those who need it on home visits.

Transportation

Needs/problems

- There is a need for transportation to and from doctors and dentist appointments.
- There is also a need for transportation to other places in addition to medical appointments such as grocery shopping and clothes shopping. There is a bus that takes residents to Target and Rainbow Foods for free but everything must be paid for.
- Transportation can be expensive. Some insurance plans will pay for transportation to medical appointments or for other reasons but those without insurance must pay themselves. Metro Mobility and East Side Neighborhood services charge 2 to 3 dollars per ride and for someone on a low income it gets to be too expensive to take these means of transportation more than a few times.
- Riding the bus is uncomfortable and bus drivers are impatient and try to hurry them along. It is difficult and unpleasant to ride the bus in cold weather.
- There are no more friendly rides in the building by those residents with cars who are capable of driving because they feel they have been taken advantage of. Some have stopped giving rides to neighbors because their passengers have not been giving them any money.
- Some resident get rides from their children or other family members but those people aren't always available.
- There is a lack of knowledge as to what transportation options are out there.

Recommendations

- The CHP should consider provided stipends to volunteer drivers living in high rise buildings, those who were previously giving rides but stopped.
- The CHP could consider having some kind of van to take clients to medical appointments.
- The CHP should keep track of transportation opportunities available to refer clients to, including NESCRC services.
- In addition to the NESCRC services, the CHP should recruit other volunteer drivers to give rides to clients.
- The CHP should consider having informational classes or printing informational materials on where residents can obtain rides.

Insurance

Needs/problems

- Insurance or lack of insurance is a problem. Many people who have Medicare have 'spin downs' so they end up paying for a lot of services out of their own pocket.
- Insurance costs are getting higher but services are reducing, "you pay more and you get less".
- Most of the residents are on some kind of medical assistance or are insured but there may be a situation where they do not qualify for Medicare yet.

There is a rule that you cannot get Medicare until two years after your officially determined disable date.

- There is too much bureaucracy in the social security/ disability, "too may hoops to jump through".
- Residents need help with paperwork and keeping bills and insurance information straight. Some don't have the mental faculties to do so and others are legally blind and cannot see to do so.

Recommendations

- The CHP should provide assistance in filling out insurance forms or dealing with paperwork, possibly through a volunteer assigned to visit a particular client who needs help.
- The CHP should try to help clients by subsiding health care costs not paid for by the clients medical plan and health care costs for those clients who may not have insurance.

Medicine

Needs/problems

- Prescriptions are expensive and insurance does not always cover their cost. There needs to be some kind of subsiding of prescription costs.
- Some residents are concerned about overmedication. One resident spoke of a friend who takes nine different medicines and has constant headaches but is told by her specialist that this many drugs is alright. It can be confusing to keep track of multiple medications and make sure they are taken at the correct time or at all.
- There is a need for more information on herbals and dietary supplements as they are becoming more popular now.

Recommendations

- The CHP should consider providing some kind of subsidy for prescription costs, but perhaps only on a dire need basis as this can be very costly for the program.
- Some pharmaceutical companies are starting Indigent Patient Programs which provide free or reduced price medications. The CHP should try to find out more information about these programs to pass along to its clients.
- The CHP should organize education classes or print informational materials to educate residents about herbal supplements.
- The CHP should have the visiting nurse set up a medication schedule for those clients who need it, and monitor their medication intake.

Housekeeping/Chores

Needs/problems

- Medicare will not pay for housekeeping so if a resident needs it and cannot afford it, they will not get it.
- There is a need for good quality housekeeping. The county provides homemaking services, but the quality of those who come has not been high. The homemakers are very particular about what they will and will not do, some do a poor job cleaning, and in one case items were stolen from a client.
- There is a great deal of paperwork involved in getting housekeeping help. If a resident is on medical assistance they must get a doctor's statement that they need to have housekeeping help and doctors are not always willing to give it. Then they must fill out paperwork for the county, which must be obtained by going downtown.
- There are laundry facilities in the building and some residents might be interested in having someone do their laundry for them and may even be willing to pay them if they can afford it.

Recommendations

- The CHP should work to identify homemaking agencies who provide good quality services to be able to refer their clients to them. This includes chore services from NESCRC as well.
- The CHP should consider recruiting some good quality volunteers to perform chore and housekeeping services for those residents who cannot afford to pay for it.

Nursing Services

Needs/problems

- There is a need for a visiting nurse to come to the high rise to give flu shots and B12 injections.
- Blood pressure checks occur "once in a blue moon". A nurse comes in to the building and does the checks in the counselor's office, so if a resident wants to have his or her b.p. checked they have to go to her. This creates problems for people who do not feel comfortable leaving their apartment and a confidentiality problem in that residents are afraid other residents will find out their blood pressure.
- Residents thought it would be nice to have a nurse on call to answer any questions they might have, like a help line to answer questions or confusion about medication or for emergency situations like overdosing on medication. One resident said that there are some other residents who are afraid to call an ambulance but would be more willing to call a nurse to tell her or him their problems/symptoms over the phone and get some kind of diagnosis or assessment of the situation first.

Recommendations

- The CHP should consider having their visiting nurse make visits as needed to the buildings to give flu shots and B12 injections.

- In some situations the CHP should consider having the visiting nurse conduct blood pressure checks in peoples' apartments.

Dental Care

Needs/problems

- There is a need for some kind of dental care in the high rises.
- There is also a need for referrals for health service providers especially dentists.

Recommendations

- The CHP should keep track of health service providers to which to refer their clients, making sure to include dentists.
- The CHP should consider conducting some kind of informational meetings to educate residents about good dental hygiene.

Nutrition

Needs/problems

- Nutrition and eating well are large problems. Some residents who have how income and/or gamble all of their money away do not have money to buy food. They depend on home delivered meals and the free food that comes form the Greater Lakes Country Food Bank. The free food is just a random assortment and they often run out of things. The food is supposed to be a supplement to their pantries but some are having to survive on this only.
- There is a need for information on sodium intake and what residents should be aware of for their blood pressure.
- Dairy products are a concern. Many residents cannot eat dairy products because they are lactose intolerant, but they need the calcium in their diets to keep from losing bone mass. Some blood pressure medicines are actually calcium blockers. They need to know how to get calcium in other ways.
- Health promotion classes about nutrition would be welcome, and there was also a need expressed for one-on-one nutritional counseling.
- Congregate dining provided by VOA (Volunteers of America) in the 1717 Washington building is not well publicized but could be open to whole neighborhood, the problem is how to open the building to non residents (the buildings are locked for security and residents have access with key cards).
- Congregate dining is not adequate. There are shortages of food, the food is poorly cooked, they are not allowed to bring food back to their apartments, the cook has a bad attitude, the food is not healthy – it has lots of gravy and is often fried.

Recommendations

- The CHP should work with a nutritionist to provide educational programs in the high rise building on healthy eating habits.

- The CHP should consider doing some kind of advocacy work with VOA on behalf of the residents to try to improve the quality of congregate dining.
- The CHP should consider talking with VOA and county staff about opening up the building for members of the neighborhood to participate in congregate dining – the is supposed to be a $2.25 donation. The county will pay if on county medical assistance.
- The CHP nurse or home health aides should make efforts to check clients homes for health foods to be sure they are eating well and help them set up a food plan if necessary.

Recreation

Needs/problems

- Some kind of low impact exercises for the elderly are needed. One resident loves the exercises she does at Eldercare and thinks it would be nice to have exercise classes at Logan Park or the Northeast Neighborhood house.
- There is an exercise bike or two available to residents at 828 Spring but this is not a good way to exercise for everyone
- Some residents requested body part specific exercises for those with arthritis or those with back problems. Another resident suggested the directions on how to do some simple exercises be posted outside the elevators for people to do with they waited.

Recommendations

- The CHP should consider working with Scott Gagnon to provide an exercise class for seniors at Logan Park and should make sure to provide transportation to the class if needed.
- The CHP should look into getting permission to post exercise posters near the elevators for residents to do while waiting.

Counseling

Needs/problems

- More information is needed on the ties between religion and better health.
- Gambling is a problem. Some residents cannot pay rent or buy food because they are losing all of their money. The Hinkley bus comes at the first of the month right when they get their social security checks to go gambling.
- Mental health issues are a problem: schizophrenia, depression. Low income is a common cause for depression when people cannot make ends meet.
- Anger issues are a problem.
- There is a need for alcohol abuse counseling. Many men and some women sit in their apartments all day and drink alcohol.

Recommendations

- The CHP should identify a variety of counseling opportunities and services to which to refer their clients, for example the Spring St. building has a well known AA group.
- The CHP should consider helping with craft or other hobby programs in the buildings to encourage residents to participate in other activities besides gambling.
- The CHP should pair up visiting volunteers with those residents feeling depressed and lonely to provide some company for them.

Educational Programs

Needs/problems

- Home safety issues are a topic of interest for a class or seminar.
- There is a need for education on ways to lower cholesterol and heart health, and on ways to deal with arthritis.
- There needs to be education on reducing the spread of infectious diseases like colds and flu and good health habits like washing hands after using the restroom and before cooking.
- There is a need for healthy cooking tips and advice like which king of cutting boards to use to prevent bacteria growth and how to keep things clean.
- There is a need for education for diabetics. They need to know what to eat and ways of getting their metabolism going to burn calories to lose weight to help with the diabetes.
- There is a need for education on taking care of plants and pets and possibly the provision of plants to some residents. Some residents are afraid of insects so would like tips on how to keep their place insect free.
- There is a need for an educational program on diversity and sensitivity to diversity. One resident notices some problems with race relations in the building.
- There is a need for educational programs about Y2K and what it means to the residents. Some residents are getting scared and worried because they don't understand with will happen. The don't understand how it will affect them or not if there are problems with computers.

Recommendations

- The CHP should consider holding a monthly health promotion educational class in each high rise building and arranging for a guest speaker to come in and cover a different topic each month (all of the topic mentioned above).
- The CHP should contact the Red Cross for assistance in planning an educational program about Y2K.
- If requested and depending on the topic, the CHP should try to provide some kind of in-home education or advising through the use of volunteers or the visiting nurse.

Language and Culture

Needs/problems

- Language is a problem as there are many residents who speak Russian and Ukrainian and little English. They need to have the rules of the building translated into their own languages. There are also some SE Asian residents and Somali residents especially in the 828 Spring St. building who need translator services.
- Residents who do not speak English need translators when they go to medical appointments.
- There needs to be some kind of sensitivity training for residents to accept cultural differences, also on sensitivity to the needs of the blind and deaf or physically impaired.

Recommendations

- The CHP should recruit volunteers in the neighborhood who speak a language other than English to help translate for residents when they have medical appointments or other needs.
- The CHP should consider sponsoring some kind of cultural sensitivity training program in the buildings.

I'm OK Checks

Needs/problems

- There is a problem with the I'm OK Checks where the residents put a card out on their door every night and then take it off in the morning to let everyone know that they made it through the night safely. They are put out at 5 pm and taken in at 9 am and no one seems to be checking them in the morning. Sometimes someone will fall in their apartment after their card has been turned and no one will check on them. They could be seriously injured or dead.
- There is a need to build neighbor connections so that someone will answer the call when people ask for help. There is a need to foster neighborly concern and care for one another, for residents to look out for one another – a buddy system.
- There is a need to meet new residents and help them get to know the building.
- Privacy is an issue. There are lots of gossip and rumors spread and the residents do not want to deal with it so do not leave their apartments. The security cameras around the building add to the paranoia and suspicion. Residents do not want to make suggestions in the newsletter box because they are afraid someone is watching them and some do not go out to get their mail until late at night to avoid seeing other residents.

Recommendations

- The CHP should work with volunteers in the buildings to do daily checks of the OK cards.
- The CHP should consider pairing up especially frail residents with another person in the building or outside it to make phone calls to the resident at the same time everyday. If the resident does not answer then someone in the building can be alerted to help the resident.

- The CHP should support current efforts in the buildings to publish a newsletter to get to know the people in the building and get them talking about other things besides gossip, to set up a photo directory of new residents, and to pair new residents up with old ones to show them around.

Miscellaneous Needs

Needs/problems

- There is a need for help with correspondence, especially for those residents who are legally blind.
- There is a need to know where to get gardening supplies and plant donations for the 1717 Washington garden in the spring.
- There is a need for hearing tests to be conducted in the building.
- There is a need for eye care or subsidies for eyeglasses costs.
- There is a need for someone to mend clothes, sew on buttons, hem up new pants, make simple alterations, etc. because the elderly with arthritis or poor eyesight cannot handle needle and thread.
- There is a need to have some building floors smoke free.
- The 828 Spring Street Building is a younger building, there are more children living there although residents in the high rises are supposed to be 18 and over. There is a need for immunizations and prenatal care.
- There is a need to find someone who has connections to free or lost cost sanitary pad, and bladder control pads (Depends)
- There is a need for new undergarments for people on very low income or who cannot go out and shop.
- Donations of money and supplies are needed for art and craft activities.
- There is a need for better access to computers. There is a computer in 1717 Washington which is supposed to be for the use of the building but it is locked in the counselor's office. One resident has a computer but doesn't know how to use it. There is a need for computer training.
- There is a desire for some kind of piano lessons or music in the building. There is a piano at 1717 Washington.
- There is a need to be more social outlets for men, as many of them do not like to come out of their rooms.
- When there are maintenance problems people do not know who to call or where to go to for help, they do not have the money to pay for repairs.

Recommendations

- The CHP should recruit volunteers to help residents learn how to use computers and should advocate on behalf of the resident to make the computer more accessible.
- The CHP should recruit volunteers to do mending and simple alterations on clothes.

- The CHP should consider working with other agencies to develop more social outlets for men – the high rise building at 1815 Central has an active men's group and they are looking for other men to get together with.
- The CHP should keep a list of maintenance and home chore providers to which to refer their clients. This can include NESCRC as well as volunteers from the neighborhood.
- The CHP should encourage visiting volunteers to help with correspondence.
- The CHP should consider bringing in some local musicians into the buildings to provide music – perhaps other talented residents in the neighborhood or school children who are learning to play piano or some other instrument.
- The CHP should make efforts to refer young families in need of immunizations or prenatal care to the appropriate places.
- The CHP should provide transportation for residents to go clothing shopping, especially for undergarments or bring some to the building for the residents to choose.

Publicity

Needs/problems

- There needs to be an events calendar posted in a central location in the buildings to let people know what events are happening.
- Publicity materials must be in large print and translated into several different languages, particularly Russian.

Recommendations

- Publicity materials for the CHP should be in large print and in several languages.
- Fliers can posted on the bulletin boards, but in order to reach everyone the CHP should distribute fliers or brochures under the doors of each apartment.
- One resident recommended that the CHP not rely solely on publicity through a religious context. She warns that people who are not interested in religion will throw brochures away before realizing that the services have nothing to do with religion.

The Neighborhood: Neighbors in their Homes Results

Interviews with residents of Logan Park and St. Anthony East who are living in their homes were conducted after the surveys had been distributed and returned. The main reason for this is because the surveys turned out to be the most successful vehicle to identify residents with whom to speak. Other methods of identifying people to interview were tried and unsuccessful including the following: recommendations or referrals from local health service providers; publishing announcements in church bulletins; posting fliers in local high traffic spots – church notice boards, laundry mat, gas station; and recommendations from the local mail carrier. A total of 47 survey respondents included their name and address on the survey. Out of this group of 47, ten neighborhood residents were selected to be interviewed about their needs and expectations for the Community Health Program. These respondents varied in age from the mid 40s to early 80s. They were predominantly female and living alone, although a few married couples were consulted. The majority of the interviews took place over the telephone, although a few were conducted in the homes of the respondents.

Similar to the high rise residents, the needs of those living at home were predominantly transportation to medical appointments, housekeeping and chore services, and friendly visiting. In speaking directly with these potential clients, the flexible nature of a community health program came through as a must. While there are general needs in the neighborhood, each resident has a situation that is unique. The CHP's job is to try and meet those needs in an individualized manner. It is my recommendation that the information obtained from these interviews be directly submitted to the CHP Outreach Coordinator to begin efforts to recruit volunteers and match services to those who need them. The survey was a useful tool to identify interview candidates in that it allowed me to speak with those who need services and those who are willing to provide services on a voluntary basis. To give a sense of the information obtained from these meetings brief write-ups of two different interviews follow:

Respondent 1

Respondent 1, "Jane", is over 80 years old. She has been living in the St. Anthony East neighborhood for over 50 years. It will be 52 years in September. She is legally blind and has a magnifier machine from Society for the Blind. She says the only reason she can stay in her home is the magnifying machine, otherwise she would not be able to pay her bills or read her mail or write letters or write checks.

She has been having some medical trouble lately. She had two back operations, a hip replacement and then was in a car accident and had a broken pelvic bone. She was in and out of a nursing home after being released from the hospital about three times – it got to be that they knew her name.

When asked what her expectations of the CHP are she mentioned specifically that she would like to take walks in her neighborhood, but because she is blind she needs help doing so. She is also worried that she might fall and so would like to have some assistance taking walks.

Friendly visiting is a need she indicated on her survey. She also marked transportation. When asked how she has been getting to her medical appointments she said that she had a boyfriend who used to drive her to the doctor and the bank, etc., but he passed away in March and she does not have anyone to take her anymore. Sometimes she said her sister will come and take her places – her sister lives in SE Mpls.- but her

sister is getting old as well and "she needs to take care of herself". Jane said that she is in pretty good health and does not need to go to the doctor very often, but does have dentist and eye doctor appointments. Also it is things like grocery shopping and going to the bank that she needs help with because of her poor vision.

When asked whether her neighbors ever helped her in a time of illness or crisis, she responded, "never", and that they have been no real help. She has been feuding with her next door neighbors because they have some "of the barkingest dogs". She said that is a "very poor neighborhood" in terms of helping each other out. There used to be one man across the street who would help everyone in the neighborhood. He has passed away now, but she said the summer before he died he was mowing six lawns on the block. "Now there's nobody here in this neighborhood", she says. She feels like she really doesn't know anybody anymore. There is one woman who shoveled her walk during the big snow storm we had in March. Her granddaughter also comes one night a week to help her with writing checks and paying bills, etc.

Jane also marked down outdoor chores on her survey. She said that sometimes her son comes to trim the bushes but sometimes she needs help. She also has a man who goes to church with her, Emanuel Lutheran Church, who mows her lawn and does some yard work. He kind of 'adopted her' she says because she was a friend of his mothers and now she has passed away. She says he is a good friend to her. She has used the chore services from NECRC in the past but has never been satisfied. She talked about one time when she had a woman come in and clean and the woman only dusted around the beds not under. Jane watched her, because although she is legally blind she can see some things. There are some chores she needs done now – one is electrical work, the light switch in her bedroom is not working properly. The faucet in her kitchen is leaking.

Jane said it is the little things that she really needs help with now. These are some of the things that her boyfriend used to do for her: setting her clocks, tightening screws, changing calendars.

When asked whether she is involved in any community activities she said "no, not unless someone comes and takes me." She could go and listen but thought that since she is blind, she could not participate much in anything. When asked whether she would like to be a CHP volunteer she said "no, I can't hardly do anything to take care of myself."

Jane is very enthusiastic about the CHP and hopes that it will do well. She thinks it is a good idea with a lot of potential because as she says, "I don't want to move out of my house, I don't want to move in an apartment. I want to say in my home as long as possible if I can."

Respondent 2

Respondent 2, "Howard", has lived in the neighborhood for 6 months. He lives with a Russian woman named "Mary".

The needs they indicated on the survey include home delivered meals, medicines evaluations, house cleaning/laundry, home nursing services, legal/insurance assistance, help with correspondence, language interpreting, education programs, personal care, outdoor chores, friendly visiting, disability assistance, nutrition, foot care, dental care, spiritual care, transportation, grocery shopping. He said that these are needs that he has noticed with neighbors here and everywhere – in other places they have lived.

Howard has personal experience with taking care of the elderly. His mother used to deliver meals on wheels when she was able. Then, when she was older, she had hospice care and he saw what a difference it made for her. It really helped a great deal.

He remembered his mother looking forward to the visits and it really made a difference for her.

He would like to volunteer to do outdoor chores like mowing lawns because he has seen through personal experience what it means to have someone come and do things like that. Howard has lived with the elderly before and has seen that many people have a yard, but "people feel overburdened and forced to move when they can't take care of their yard".

Howard also indicated that since Mary speaks Russian, she would like to volunteer as a Russian translator.

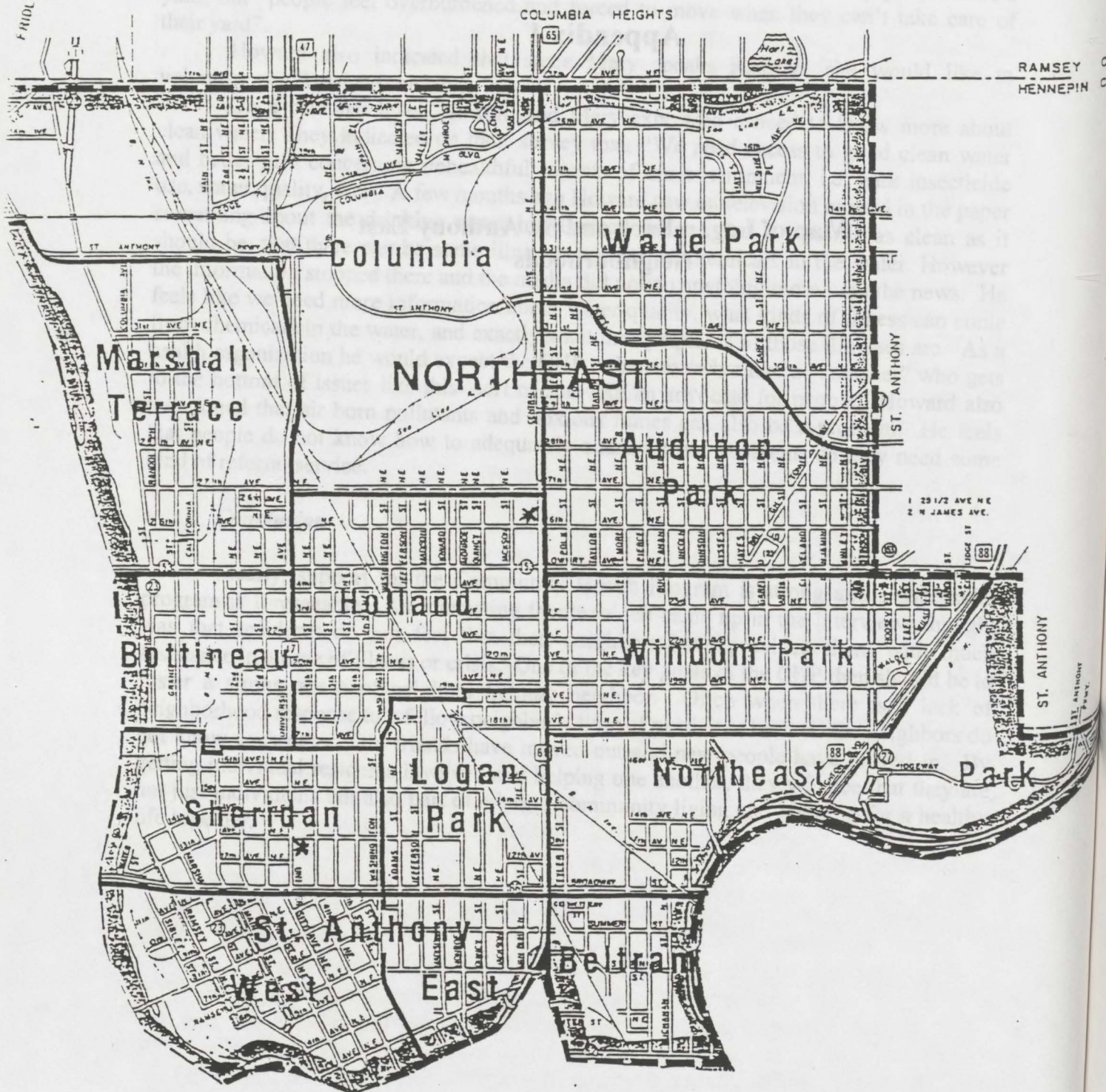
On a personal level, Howard and Mary expressed a need to know more about clean water. They indicated on their survey that, "We need access to good clean water and better info concerning unhealthful aspects of our environment, i.e. park insecticide use, water quality, etc." A few months ago Howard saw on television or read in the paper something about the drinking water in Minneapolis and that it was not as clean as it should be, that there can be some illnesses caused by chemicals in the water. However the information stopped there and the media did not do anything more with the news. He feels like we need more information about water quality, what kinds of illness can come from chemicals in the water, and exactly what the symptoms of those illnesses are. As a health organization he would expect the CHP to be somewhat like a "crusader" who gets to the bottom of issues like this- sort of acts like an advocate for people. Howard also mentioned that air born pollutants and noxious fumes can also be a problem. He feels that people do not know how to adequately address these problems so they need some kind of referral service.

Conclusion

Clearly, support for the Community Health Program is strong and a successful program is foreseeable. An interesting theme which came up in the interviews though, was that residents do not feel that their neighbors have provided them with much assistance in a time of illness or crisis. One of the key goals of the CHP then should be to foster a strong sense of neighbor helping neighbor. Often when there is a lack of neighborhood response to a fellow neighbor's time of need, it is because the neighbors do not know each other. Old friends have moved out and new people have moved in. By getting individual residents involved and helping one another, they will see that they are not just individuals but also part of a larger community living and working for a healthy life together.

Appendix 1

Map of Logan Park and St. Anthony East Neighborhoods


COLUMBIA HEIGHTS
RAMSEY CO.
HENNEPIN CO.
Columbia
Waite Park
NORTHEAST
Marshall
Terrace
Audubon
Park
Holland
Bottineau
Windom Park
Logan
Park
Northeast
Park
Sheridan
St. Anthony
West
St. Anthony
East
Beltram
ST. ANTHONY
ST. ANTHONY

Appendix 2

Logan Park-St. Anthony East
Community Health Program Survey

LOGAN PARK - ST. ANTHONY EAST
COMMUNITY HEALTH PROGRAM

NE Senior Citizens Resource Center
697 13th Avenue NE, Minneapolis, MN 55413
(612) 781-5096

March 22, 1999

Dear Logan Park – St. Anthony East Resident,

Welcome to the Logan Park and St. Anthony East neighborhoods. We hope you like living here and feel at home. We want your experience in this neighborhood to be a good one. And, if you are having difficulties, we want you to know that we are ready to give you a hand. Logan Park and St. Anthony East care about your health and well being. Last fall both the Logan Park and St. Anthony East neighborhoods voted to spend NRP money on a Community Health Program.

The Community Health Program is about neighbors helping neighbors to meet the health care related needs in our neighborhoods, *your* health care needs. Some of you may need a visit from a neighbor who also happens to be a registered nurse or home health aide. Others of you might need a visit or advice from a friend down the block. Or maybe you need the phone number of a place to take your sick child.

Whatever your needs are, the Community Health Program wants to try our best to meet them. To do this we need your help. What kind of help do you need in order to improve your life? How can we, your neighbors, help you? We want to know the answers to these questions. This is why we are asking you to fill out this survey. The results will be used in a couple of ways. First, it will give us an idea of your needs and how your neighbors can help you. Second, it will help us identify our neighbors who are willing to share their time and talents with each other.

Your completed survey will be used only for Community Health Program purposes and will not be shared with other organizations. If you are interested in receiving a summary of the survey results please contact the Community Health Program at the address or phone number above.

Thank you for your assistance! The Logan Park-St. Anthony East Community Health Program, your neighbors, are looking forward to serving you.

Sincerely,

Clareyse Nelson-St. Anthony East
Steering Committee Co-Chair
Logan Park-St. Anthony East
Community Health Program

Margi Orman- Logan Park
Steering Committee Co-Chair
Logan Park-St. Anthony East
Community Health Program

COMMUNITY HEALTH PROGRAM SURVEY

Please circle the letter or number which corresponds to the answer closest to your opinion or current situation, or fill in the information requested. All individual responses will be kept confidential.

1. Do you have the following: (*Circle all that apply.*)

   a. Health insurance
   b. Medicare
   c. Medical assistance
   d. Minnesota Care
   e. Food Stamps/AFDC
   f. SSI/General Assistance
   g. Other health care insurance or assistance (*Specify*:_____)
   h. None of these

2. Do you use the following types of transportation? (*Circle all that apply.*)

   a. Car
   b. Can use the bus
   c. Metro Mobility
   d. Other (*Specify*:_____)
   e. None of these

3. When was the last time you visited a doctor? (*Circle one.*)

   1. Within the last month
   2. 1 to 6 months ago
   3. 6 to 12 months ago
   4. 1 to 2 years ago
   5. 2 to 5 years ago
   6. More than 5 years ago

4. Where do you get health care? (*Circle all that apply.*)

   a. In your home
   b. At a neighborhood clinic (*Which clinic*:_____)
   c. Hennepin County Hospital Clinic
   d. Emergency room
   e. Other (*Specify*:_____)

5 Which of the following are problems for you in getting health care? (*Circle all that apply.*)

a. No health insurance
b. Not enough health insurance
c. Cost of health care
d. Lack of transportation
e. Not knowing a doctor in this area
f. You don't feel comfortable seeing a doctor
g. Language
h. Lack of child care
i. Other (*Specify*:_____)

6. Which of the following services do you think are needed by people in your household or in your neighborhood? (*Circle all that apply.*)

a. Home delivered meals
b. Medication evaluations
c. House cleaning/laundry
d. Home nursing services
e. Legal/insurance assistance
f. Help with correspondence
g. Drug/alcohol abuse counseling
h. Other types of counseling
i. Relief for caregivers
j. Language interpreting
k. Senior dining
l. Education programs
m. Personal care
n. Outdoor chores
o. Recreation
p. Pet care
q. Quit smoking programs
r. Friendly visiting
s. Money management
t. Disability assistance
u. Nutrition/exercise
v. Foot care
w. Dental care
x. Home safety assessments
y. Spiritual care
z. Parenting advice
aa. Transportation
bb. Grocery shopping
cc. Other (*Specify*:_____)

7. Do you currently provide care to an elderly person (parent, spouse, relative, friend)?

1. Yes ----------> What type of care do you provide?

2. No _____

8. Are you interested in providing any of the following volunteer services for the Community Health Program? (*Circle all that apply.*)

a. Transportation/driving
b. Home visits/companionship
c. Meal preparation
d. Child care
e. Household chores
f. Language translation ------> Which language(s)? _____
g. Other service (*Specify*:_____)

9. Including yourself, how many people are currently living in your household?

_____ people

10. How many of the people in your household are over the age of 65?

_____ people over 65

11. What is the age of the oldest person in your household?

_____ years

12. Which of the following best describes your race or ethnic background? (*Circle one.*)

1. African
2. African American
3. American Indian/Native American
4. Asian
5. Asian American (born in U.S.)
6. Hispanic
7. White/Caucasian (not Hispanic)
8. Other (*Specify*:_____)

13. Are you:

1. Female
2. Male

14. In what year were you born? ____ ____ ____ ____

You do not need to give your name or address or phone number, but it would help to determine who may need our services. If you have any questions or would like more information, or if you wish to volunteer, please call 612-781-5096 and ask for Rick or Blythe.

Name: _____

Address: _____
(Street) (Apt.#)

_____
(City) (State) (Zip code)

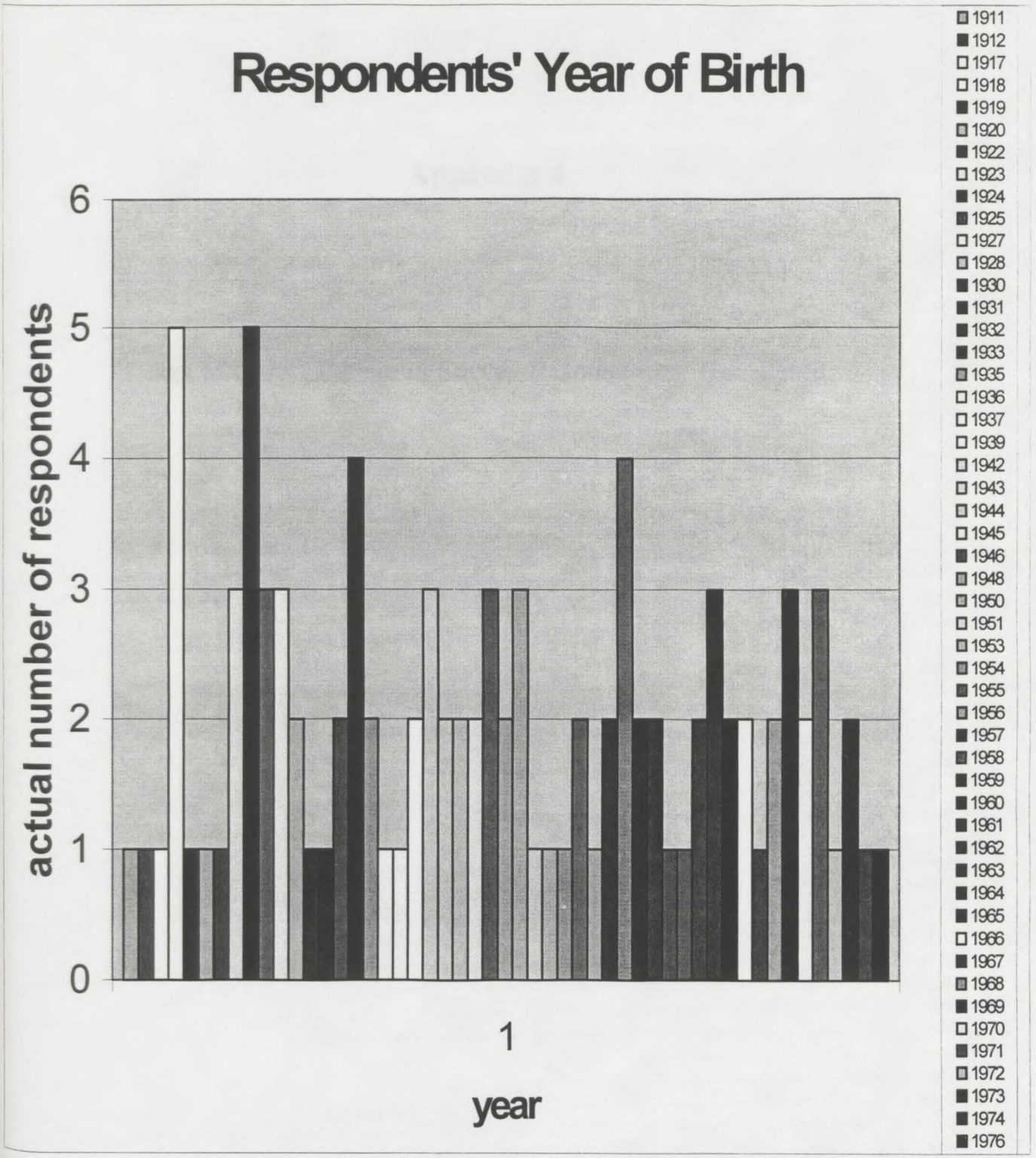
Phone: _____

Thank you very much for your help!
Please return your completed survey in the envelope provided to
The North East Senior Citizens Resource Center, 697 13th Avenue NE, Minneapolis, MN 55413

Appendix 3

Year of Birth of Survey Respondents

Year of Birth	Actual # of Respondents Born in that Year
1911	1
1912	1
1917	1
1918	5
1919	1
1920	1
1922	1
1923	3
1924	5
1925	3
1927	3
1928	2
1930	1
1931	1
1932	2
1933	4
1935	2
1936	1
1937	1
1939	2
1942	3
1943	2
1944	2
1945	2
1946	3
1948	2
1950	3
1951	1
1953	1
1954	1
1955	2
1956	1
1957	2
1958	4
1959	2
1960	2
1961	1
1962	1
1963	2
1964	3
1965	2
1966	2
1967	1
1968	2
1969	3
1970	2
1971	3
1972	1
1973	2
1974	1
1976	1


Respondents' Year of Birth
actual number of respondents
0
1
2
3
4
5
6
1
year
1911
1912
1917
1918
1919
1920
1922
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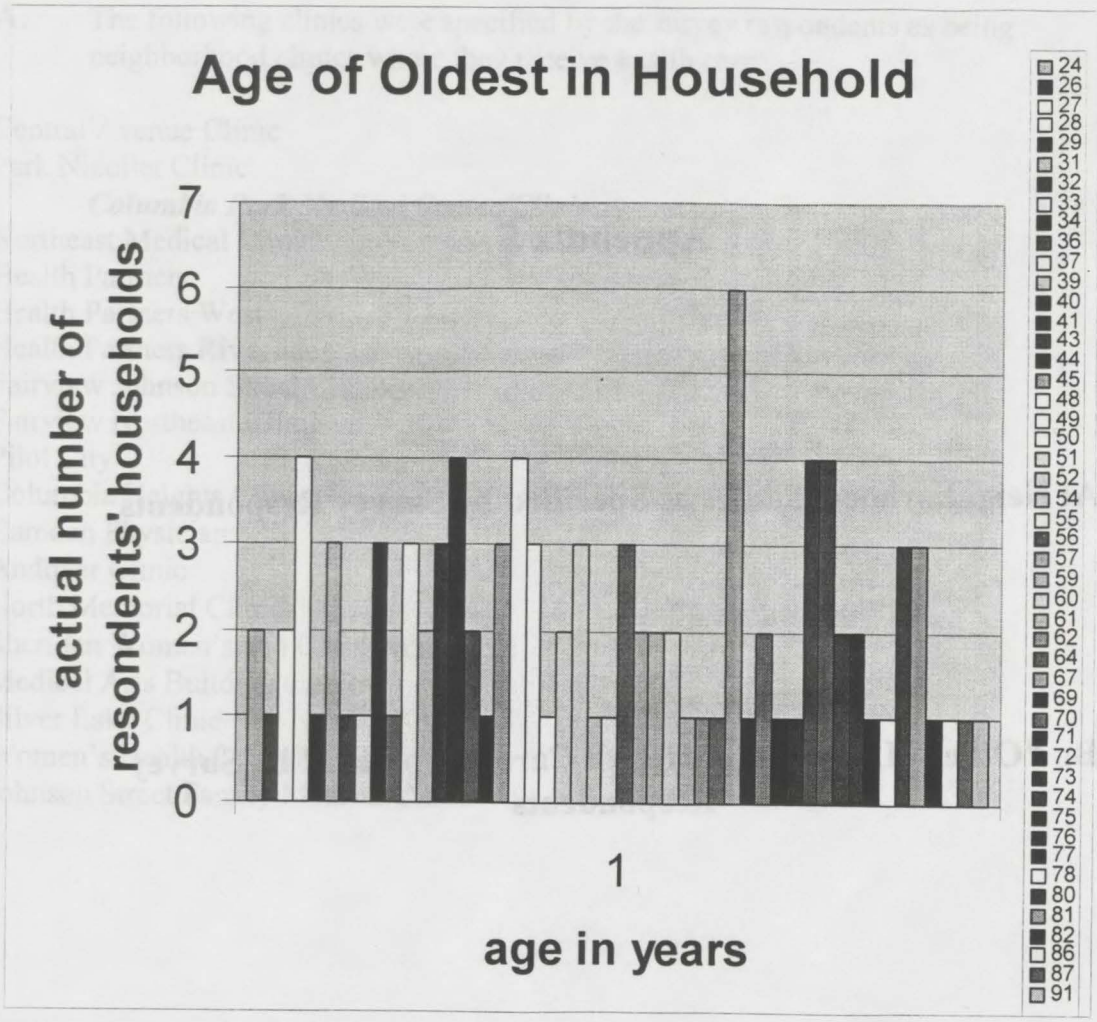
1968
1969
1970
1971
1972
1973
1974
1976

Appendix 4

Age of Oldest Person in Survey Respondents' Household

Age	Actual # of Households in Which the Oldest Person is that Age
24	2
26	1
27	2
28	4
29	1
31	3
32	1
33	1
34	3
36	1
37	3
39	2
40	3
41	4
43	2
44	1
45	3
48	4
49	3
50	1
51	2
52	3
54	1
55	1
56	3
57	2
59	2
60	2
61	1
62	1
64	1
67	6
69	1
70	2
71	1
72	1
73	4
74	4
75	2
76	2
77	1
78	1
80	3
81	3
82	1
86	1
87	1
91	1


Age of Oldest in Household
actual number of resondents' households
0
1
2
3
4
5
6
7
1
age in years
24
26
27
28
29
31
32
33
34
36
37
39
40
41
43
44
45
48
49
50
51
52
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80
81
82
86
87
91

Appendix 5

A: Neighborhood Clinics as Specified by Survey Respondents

B: "Other" Locations of Health Care as Specified by Survey Respondents

A. The following clinics were specified by the survey respondents as being neighborhood clinics where they receive health care:

Central Avenue Clinic
Park Nicollet Clinic
Columbia Park Medical Center/Clinic
Northeast Medical Clinic
Health Partners
Health Partners West
Health Partners Riverside
Fairview Johnson Street Clinic
Fairview Northeast Clinic
Pilot City
Columbia Heights Clinic
Camden Physicians
Andover Clinic
North Memorial Clinic
Sheridan Women's and Children's Clinic
Medical Arts Building Clinic
Silver Lake Clinic
Women's Health Consultants
Johnson Street Family Medical Clinic

B. The following locations were specified by the survey respondents as "other" places where they receive health care:

Boynton Clinic (U of Minnesota)
Columbia Park
Unity Hospital
Medical Arts Building Clinic
Fridley Clinic
Fairview Hospital Clinic
Fairview Northeast Clinic
Fairview Johnson Street Clinic
Health Partners
Health Partners Riverside
Health Partners Como
Health Partners Blaidell/Meadowbrook
Alternative Health Partners
Dr. Gary Good – Columbia Heights
North Memorial Clinic and Hospital
HMO Park Nicollet Clinic
North Clinic
Bloomington Lake Clinic
Fridley Clinic
Silver Lake Clinic
Bolan Clinic- St. Paul
Children's Health Care – Minneapolis
"clinic in network of insurance company"
"clinics in St. Paul/South Minneapolis"
Northwest Clinic
"private physician"
Park Nicollet Medical Center/Clinic
Oakdale Medical Center
Camden Physicians/Clinic
Associates in Women's Health, Medical Arts Building
University Hospital Clinic
"shopping for doctors"
Mayo Clinic
VA Hospital
Creekside Family Physicians – St. Louis Park
Greencentral community Clinic